County of Los Angeles
CHIEF EXECUTIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://ceo.lacounty.gov

DAVID E. JANSSEN
Chief Executive Officer

July 17, 2007

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF AND AUTHORIZATION TO IMPLEMENT CORRECTIVE ACTION PLAN FOR COUNTYWIDE ENHANCED SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES (ALL AFFECTED) (3 VOTES)

JOINT RECOMMENDATIONS WITH DIRECTORS OF THE DEPARTMENTS OF MENTAL HEALTH AND CHILDREN AND FAMILY SERVICES THAT YOUR BOARD:

1. Approve the Court-ordered modifications to the Countywide Enhanced Specialized Foster Care Mental Health Services Plan (County Plan), as described in Attachment I, to increase the screening and provision of mental health services to children who are not yet in foster care placement by the Department of Children and Family Services (DCFS), but who are at imminent risk of entering foster care placement ("at-risk population"), greater expansion of intensive in-home mental health services, including Wraparound and Treatment Foster Care services, systems to more quickly transition children out of congregate care settings, and systems to better monitor outcomes that children are achieving, at a projected annual cost of $90.3 million funded with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State General Funds (SGF), EPSDT-Federal Financial Participation (FFP) Medi-Cal, and Intrafund Transfer (IFT) from DCFS, as detailed in Attachment II.

2. Authorize the implementation of the modified County Plan in Service Areas (SA) 1, 6 and 7 and Countywide implementation of the increased Wraparound and Treatment Foster Care services and expansion of the Multidisciplinary Assessment Team program, subject to approval of the financing and staffing requirements which will be included in the Departments' FY 2007-08 Budgets during the Supplemental Changes phase of the budget process.

3. Delegate authority to the Director of Mental Health or his designee to prepare, sign and execute Amendments, substantially similar to Attachment III, to Agreements with DMH contractors selected to provide the Foster Family Agency, Wraparound and Treatment Foster Care mental health services, subject to approval of the financing requirements, which will be included in the DMH FY 2007-08 Budget during the Supplemental Changes phase of the budget process.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of the recommended actions will enable DMH and DCFS to develop and implement the Court-ordered changes to the services reflected in the County Plan. This Corrective Action Plan has been prepared in direct response to the November 2006 Findings of Fact and Conclusions of Law Order issued by Hon. Howard A. Matz, United States District Court, Central District of California, with respect to the settlement reached in the Katie A., etc. v. Bonta, et al., Case No. CV 02-05662 AHM (ShX) ("Katie A.") lawsuit. The Katie A. Settlement Agreement was approved by your Board in July 2003, and the original County Plan to implement the Settlement Agreement was approved by your Board on October 11, 2005.

With these modifications to the County Plan, additional and enhanced systems will be put into place to ensure screening and provision of mental health services to children who have not yet been removed from their homes, but who are in need of ongoing child welfare services, such as Family Maintenance Services, Voluntary Family Maintenance Services, and Voluntary Family reunification, and children in Foster Family Agency (FFA) foster homes; greater expansion of intensive in-home mental health services, including Wraparound and Treatment Foster care services; development of expanded comprehensive, community-based, culturally relevant treatment programs to more quickly and effectively transition children out of congregate care settings; and implementation of systems to better monitor the outcomes that children are achieving. Further, the modified plan includes the Countywide expansion of the Multidisciplinary Assessment Treatment (MAT) program and the development of a process to assess and monitor the effectiveness of training activities related to the new service delivery system.

While the Court-ordered changes to the Plan are significant, DMH and DCFS are committed to integrating these activities into a broader and larger mission to more effectively identify the child's needs in the context of the family and the development of an array of clinical, support and placement services to meet these needs. These improved services will be grounded in improvements in utilization and access management, community network development, provider development and financing strategies, using a needs-based planning approach for both child welfare and mental health systems.

Given the geography and size of the County and the multiple challenges and complexities associated with meeting the terms of the Settlement Agreement, DMH and DCFS are proposing a phased-in approach to implementing these services and achieving these tasks.

In terms of sequence, DMH and DCFS will first address the areas of the Phase I programs that require enhancements as identified in either the Court Order or by Health Management Associates (HMA), in their evaluation findings. HMA is an organization engaged by the County to evaluate the implementation of Phase I of the Plan to identify areas of strengths and weaknesses to inform Countywide, or Phase 2, implementation. Specifically targeted are improvements and expansion of the DMH co-located activities to include the capacity to screen and assess children at risk of involvement in the child welfare system, as well as the expansion of the Wraparound program and the development of Treatment Foster Care capacity by January 2008.

Secondly, DMH and DCFS will address those issues identified by both the Katie A. Advisory Panel and the HMA evaluation report, including the development of infrastructure to support planning, implementation and management of data related to needs assessments, service delivery and outcomes for mental health and child welfare interventions.

Further, DMH and DCFS will put in place activities that will provide the foundation for broader needs assessment, including the screening, assessment and treatment of children and youth in home and relative placements, as well as those in D-rate placements.

Finally, DMH and DCFS will implement an array of service models that offer a continuum of best practice approaches drawing on scientific literature, consultation with the Katie A. Advisory Panel and other experts, and analysis of data relative to service needs. All of these endeavors will need to be supported by the development of a flexible and blended approach to funding that includes Title IV-E, EPSDT, County General Funds and the Mental Health Services Act.

Implementation of Strategic Plan Goals

The recommended Board actions are consistent with the principles of the Countywide Strategic Plan: Organizational Goal No. 1, "Service Excellence" - Provide the public with easy access to quality information and services that are both beneficial and responsive; Goal No. 3, "Organizational Effectiveness" - Ensure that service delivery systems are efficient, effective, and goal-oriented; Programmatic Goal No. 5, "Children and Families Well-Being" - Improve the well-being of children and families in the County of Los Angeles; and Goal No. 7, "Health and Mental Health" - Implement a client-centered, information-

based health and mental health services delivery system that provides cost-effective and quality services across County departments.

FISCAL IMPACT/FINANCING

As shown in Attachment II, the total costs for these services, including additional staffing for DMH and DCFS, are estimated at $90.3 million, funded with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State General Funds (SGF), EPSDT-Federal Financial Participation (FFP) Medi-Cal, and Intrafund Transfer (IFT) from DCFS, subject to approval by your Board in separate adjustments to the DMH and DCFS budgets. The annualized net County cost impact is projected to be $33.3 million when fully implemented.

These preliminary estimates and staffing requests have been developed by DMH and DCFS, and are provided currently in order to present your Board with an estimate of the potential costs of the Corrective Action Plan, as drafted. The estimates and staffing requests will be further reviewed in detail by my office, in collaboration with the affected Departments, prior to implementation of the services.

The associated adjustments to the Departments' FY 2007-08 budgets will be developed during the Supplemental Changes phase of the budget process, and included in our Supplemental Changes recommendations anticipated to be brought to your Board for approval in September 2007. Funding in future years will be included in the Departments' Proposed Budget requests and our multi-year financial forecasts.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In 2002, a class action lawsuit ("Katie A.") was filed against the State of California and Los Angeles County alleging that children in contact with the County's foster care system were not receiving mental health and other services to which they were entitled. In July 2003, the County entered into a Settlement Agreement resolving the County portion of the litigation. Among other things, the Settlement Agreement established an Advisory Panel to assist the County in developing plans for meeting the obligations of this Agreement and report to the Federal District Court on the County's progress in doing so. On August 16, 2005, the Advisory Panel issued its Fifth Report concluding that the County had not developed a sufficient plan to meet the needs of the plaintiff class, therefore not meeting the obligations of the Settlement Agreement.

In response to this finding, the County developed the Countywide Enhanced Specialized Foster Care Mental Health Services Plan (County Plan), approved by your Board on October 11, 2005. The County Plan was to be implemented in two phases with Phase 1

addressing the needs of children and families in DMH Service Areas 1, 6 and 7. Phase 2 would cover the remaining Service Areas and would occur after the Phase 1 implementation was evaluated to ensure that lessons learned would inform the development and implementation of Phase 2.

In November 2006, the Federal Court ordered the County to make a number of modifications to the County Plan. The senior executive staff of DMH and DCFS worked with the Panel and plaintiffs' attorneys to modify the County Plan in accordance with the Court Order, as discussed above.

The proposed actions have been reviewed and approved by County Counsel and the CEO, subject to further refinements to the financial and staffing recommendations.

CONTRACTING PROCESS

One of the requested actions is to delegate authority to the DMH Director to augment the amount of funding in existing contracts for specialized mental health services to children under the care of DCFS. DMH will identify and select, in accordance with County directives and guidelines, contracted mental health providers to which EPSDT funds will be allocated to expand mental health services. This delegated authority is requested in order to expedite the process of implementing these additional services.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The modified County Plan will significantly improve the availability and access to mental health services for children and families in the foster care systems. The MAT programs will be expanded Countywide. Additionally, the expansion of Wraparound programs and the development of Treatment Foster Care services will allow children in congregate care to receive services in a community and home-like environment. Further, this modified County Plan will further solidify the current enhanced collaboration between DMH and DCFS to address the needs of this high-risk group of children and their families.

The Departments of Mental Health and Children and Family Services will each need one (1) copy of the adopted Board actions. It is requested that the Executive Officer, Board of Supervisors, notifies the DMH Contracts Development and Administration Division at (213) 738-4684 and the DCFS Director's Office at (213) 351-5600 when these documents are available.

Respectfully submitted,

DAVID E. JANSSEN
Chief Executive Officer

DEJ:SRH
SAS:bjs

Attachments (3)

c: County Counsel
Auditor-Controller
Director, Department of Children and Family Services
Director, Department of Mental Health
Chairperson, Mental Health Commission

ATTACHMENT I

County of Los Angeles
Department of Children and Family Services
Department of Mental Health

Enhanced Specialized Foster Care Mental Health Services
Corrective Action Plan

June 28, 2007

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County of Los Angeles
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Executive Summary

Legal Background

In 2002, a class action lawsuit (Katie A.) was filed against the State and County alleging that children in contact with the County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a settlement agreement resolving the County-portion of the lawsuit.

Under the terms of the settlement agreement, the County is obligated to make a number of systemic improvements to better serve children with mental health needs. The settlement agreement also established an Advisory Panel to assist the County in developing plans for meeting the obligations of the settlement agreement and to report to the Court on the County's progress in doing so.

Enhanced Specialized Foster Care Mental Health Services

In response to this finding, the County developed the Enhanced Specialized Foster Care Mental Health Services Plan (County Plan) which was approved by the Board on October 11, 2005.

The County Plan provided for a number of systemic improvements to better meet the mental health needs of the plaintiff class. These improvements included expansion of the Medical Hubs, standardized mental health screenings for all children entering foster care, the co-location of mental health staff in DCFS offices, and increases in the County's capacity to provide intensive in-home mental health services.

Required Plan Modifications

In November 2006, the Court in Katie A. ordered the County to make a number of modifications to the County Plan. The senior executive staff of DMH and

DCFS has worked to modify the County Plan in accordance with the Court order. These modifications include:

- An expanded and coordinated system for the screening, assessment, and provision of mental health services to children at risk of entering the child welfare system, newly detained children, and children already receiving child welfare services
- The creation of a Resource Management Process to improve the identification and matching of client needs and strengths with existing and emerging clinical services and placement options
- An expansion of intensive in-home mental health services including Wraparound and Treatment Foster Care services to be used as an alternative to congregate care
- Newly developed systems to provide for better meeting the mental health needs of children in Foster Family Agencies
- The creation of youth and family support teams to provide 24/7 crisis stabilization and ongoing support to high needs children and their foster family caretakers in order to prevent placement disruptions, escalating behavioral and emotional problems, and transitions to higher levels of care
- The promotion of new treatment models that employ the concepts and skills associated with evidence-based and other best practice models in both mental health and child welfare to higher levels of care to improve both child welfare and mental health outcomes for children and families
- Improvements to the training provided to child welfare and mental health staff, informed by the experiences of front-line staff
- An evaluation of available and possibly new funding strategies, with consideration of a redistribution of available funds in a more targeted and flexible fashion to provided needed services and supports
- An improved ability to collect, manage, and utilize both child welfare and mental health information regarding client needs and strengths, service delivery, and outcomes

In some instances, the modified plan calls for initial implementation of the proposed activity in Service Areas 1,6, and 7 (Phase One) while other initiatives, such as expanded Wraparound capacity, the enhancement of the Multidisciplinary Assessment Team (MAT) process, and the improved mental health services for children in Foster Family Agencies, are scheduled for countywide implementation in FY 2007-08. Phase Two of the County Plan will provide for the countywide implementation of the various initiatives associated with both the initial County Plan and those modifications now proposed.

The total projected cost (net appropriation) for the these services and supports is $86,849,000 with revenues to include Medi-Cal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), Medi-Cal Administrative Activity (MAA), MacLaren designated funds, and County General Funds.

County of Los Angeles
Department of Children and Family Services
Department of Mental Health

Enhanced Specialized Foster Care Mental Health Services
Corrective Action Plan

Preface

The following Corrective Action Plan has been prepared in direct response to the November 2006 Findings of Fact and Conclusions of Law Order issued by Federal District Court Judge Howard Matz with respect to the Katie A. lawsuit and Settlement Agreement. It should be noted that these proposed activities/modifications to the original Enhanced Specialized Foster Care Mental Health Services Plan (County Plan) approved by the Los Angeles County Board of Supervisors (Board) in October 2005 must, however, be understood and undertaken in the context of larger, ongoing strategic planning and various initiatives currently in process within both the Department of Children and Family Services (DCFS) and the Department of Mental Health (DMH).

While the Departments propose to amend the original County Plan in significant ways consistent with the November 2006 Order of Judge Matz, they are also committed working with the Katie A. Panel and plaintiff attorneys to support these activities through their integration into these broader activities. Fundamental to both the County Plan and the larger vision and missions of the two Departments is a focus on the identification of child and family needs and the development of an array of clinical, support, and placement services to meet those needs. The development of these services should be grounded in improvements in utilization and access management, community network development, provider development, and financing strategies using a needs-based planning approach for both child welfare and mental health systems. Ongoing planning efforts by both Departments will include a performance analysis framework that will provide a cross-cutting analysis of organizational structures, core job functions, and social work and mental health service processes with the goal of creating a comprehensive, integrated, efficient, and effective service system.

Background

In 2002, a class action lawsuit (Katie A.) was filed against the State and County alleging that children in contact with the County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a settlement agreement resolving the County-portion of the lawsuit.

Under the terms of the settlement agreement, the County is obligated to make a number of systemic improvements to better serve children with mental health needs. Specifically, the County must ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

The settlement agreement defines class members as all children who:

a) Are in the custody of the Los Angeles County DCFS in foster care or who are at imminent risk of foster care placement by the Department; and
b) Are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program;
c) Have a mental illness or condition that is documented or, had an assessment been completed, could have been documented;
d) Need individualized mental health services to treat or ameliorate their illness or condition.

The settlement agreement also established an Advisory Panel (Panel) to assist the County in developing plans for meeting the obligations of the settlement agreement and to report to the Court on the County's progress in doing so. On August 16, 2005, the Advisory Panel issued its Fifth Report concluding that the County had not developed a sufficient plan to meet the needs of the plaintiff class and was not meeting the obligations of the settlement agreement.

In response to this finding, the County developed the County Plan which was approved by the Board on October 11, 2005.

The County Plan calls for a number of systemic improvements to better meet the mental health needs of the plaintiff class. These improvements include expansion of the Medical Hubs, standardized mental health screenings for all children entering foster care, the co-location of mental health staff in DCFS offices, and increases in the County's capacity to provide intensive in-home mental health services.

The County Plan will be implemented in two phases: Phase One will cover Service Areas 1, 6 and 7; and Phase Two will cover the remainder of the County. Phase One is currently underway, and Phase Two is still being planned.

In November 2006, the Court in Katie A. ordered the County to make a number of modifications to the County Plan. The senior executive staff of DMH and DCFS has worked to modify the County Plan in accordance with the Court order. These modifications include the addition of systems for the screening and provision of mental

health services to at risk population, greater expansion of intensive in-home mental health services including Wraparound and Treatment Foster Care services, systems to more quickly transition children out of congregate care settings, and systems to better monitor outcomes children are achieving. It is these modifications that are now being presented to the Board for review and approval.

Status of Plan Implementation

Since the County Plan was authorized by the Board in October 2005, the County has made substantial progress in achievement of the tasks related to the broad objectives of Phase One of the plan. In summary, the objectives of the County Plan included:

a) improved coordination of child welfare and mental health services;
b) establishment of mental health units within each DCFS regional offices and Medical Hubs to provide systems navigation, case management consultation and training;
c) promptly provide the necessary, individualized mental health services to these children/youth in their own homes or a family setting; and
d) enhanced accountability at the service provider and systems level for improved service delivery and outcomes.

In regards to coordination of services, DMH has created the Child Welfare Division that serves as the dedicated linkage with DCFS for child welfare mental health services. Weekly meetings are held with DMH Child Welfare Division staff and DCFS administration to coordinate planning and delivery of services and various initiatives.

The County has also successfully implemented the co-location of DMH staff in the eight regional offices located in the Phase One Services Areas creating capacity for systems navigation, case management, consultation, and training services. DCFS and the Department of Health Services (DHS) have established six Medical Hubs where children can receive medical examinations and mental health screenings. The DMH/DCFS D-rate case management unit is fully staffed and is tracking the delivery of services to children placed in D-rate homes.

While there has been much progress in increasing the availability of an array of "basic" mental health services for children in foster care, the County has been challenged in the implementation of the intensive in-home services component of the County Plan. However, the County has increased capacity to offer intensive in-home services through the implementation of the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan Full Service Partnerships (FSPs). Children and youth in foster care are one of the mandated focal populations for this the MHSA-CSS Plan. Further, it is anticipated that the intensive in-home services envisioned in the County Plan will be available by fall 2007. Agencies to provide these services have been selected and have attended a number of pre-implementation planning meetings. Contract amendments

will be effective July 1, 2007, and training in the evidence-based practices that constitute these programs is scheduled to begin July 11, 2007.

In regards to the enhanced accountability objective, the County has made some progress, primarily in the area of selection of performance indicators, as well as staff training and coaching. Staff providing Basic Mental Health Services as part of the County Plan has been trained in the use of the Outcomes Measures Application, a comprehensive assessment of client functioning, allowing for tracking of client outcomes. The development of the DMH/DCFS Master Person Index has been constrained by legal issues related to confidentiality and data sharing. This issue has largely been resolved with the issuance of the July 11, 2006 Order of Judge Matz which provides for the sharing of mental health information with DCFS for the purpose of conducting a client match and identifying those clients served by both Departments.

Implementation Evaluation

After much delay in the identification of an entity to evaluate the implementation of the County Plan, a vendor, Health Management Associates (HMA), was selected and has completed much of their work. They have provided the Departments with an initial draft of their findings and recommendations dated May 31, 2007, and their final report will be provided by June 30, 2007.

The draft HMA report concludes with discussion of "the most critical issues requiring attention before the County embarks on Phase Two." (HMA draft report, 5/31/07, page 49) The report recommends a variety of activities aimed at improving co-located mental health services, developing information collection and sharing capacity, reducing variation in service area implementation, improving staffing problems relating to recruitment and retention of staff, enhancing staff training, revising the screening and assessment process, promoting access to services via changes to the County's contracting process and funding of mental health services.

In summary, the report is cautionary in regard to expansion of the current implementation efforts prior to addressing these foundation issues.

Overarching Values

DCFS and DMH share an interest in the safety, permanency, and well-being of children and families in Los Angeles County. The two Departments have committed to a collaborative undertaking to improve the lives of children and families consistent with the following overarching values.

Necessary reform will require the coordination and integration of Departmental initiatives in a manner that is mutually supportive and reinforcing:

a) In many cases, fundamental practice change will be required to achieve the goals of the settlement agreement;
b) Practice change should be informed by best practice and evidence-based practice standards, benefiting from significant learning in both the child welfare and mental health fields in recent years;
c) Planning, implementation, and modifications to practice should be based on the analysis of quantitative and qualitative data regarding client needs and strengths, service delivery approaches, and client outcomes; and
d) The financial supports for these reform efforts will require a redistribution of available funds and their deployment in a flexible and targeted fashion.

Ongoing Objectives

The County's efforts remain consistent with the objectives of the settlement agreement. The primary objectives of the County Plan are the:

a) Integration and coordination of the County's child welfare and children's mental health programs, policies, and practices;
b) Prompt identification of the mental health needs of children served by the child welfare system as well as those at risk of entering the child welfare system coordinated and stage cross the child welfare system, including Emergency Response, Family Maintenance, Family Reunification, and Permanency;
c) Provision of quality assessment and flexible treatment services to those in need of treatment in order to reduce removals from family, promote permanency and stability of the child's living arrangement, and foster child and family well-being;
d) Reduced reliance on congregate care and out-of-home placements for foster youth; and
e) Development of a continuum of intensive in-home mental health services to promote family stability, reduce out-of-home placements, and provide an alternative to congregate care.

With these overarching values and shared objectives, the Departments propose significant modifications to the original County Plan. These modifications conform largely to the eleven major areas identified by Judge Matz in his November 2006 Findings of Facts and Conclusions of Law as requiring revision. The County officials with the primary responsibility for the actions proposed here are DCFS Medical Director Dr. Charles Sophy and DMH Deputy Director Sandra D. Thomas. (Additional key staff members within the Departments who will have significant responsibilities for plan implementation are identified within each subject area.)

Given the size of the County and the multiple challenges and complexities associated with meeting the terms of the settlement agreement and the cautionary tone of the HMA evaluation, the County proposes to take a staged and considered approach to these tasks.

- First, the County will address those issues identified in the HMA report as Phase One activities that require additional attention, especially those related to improvements in practice at the co-located programs and the implementation of the intensive in-home mental health services. At the same time, the County will move to implement those activities identified in the November Order attached to specific time frames such as the expansion of the Wraparound program and the development of Treatment Foster Care capacity.

- Second, the County will address those issues identified by both the Panel and the HMA report as needing attention, including the development of infrastructure for planning and implementation purposes and the capacity to collect, analyze, and report information related to needs assessment, service delivery, and outcomes for both child welfare and mental health.

- Third, the County will move to implement those activities that will provide the foundation for broader needs assessment including the screening, assessment, and treatment of children and youth in home and relative placements, as well as those in D-rate placements, and to establish a utilization management system, the Resource Management Process (RMP), by which to match the needs to services in a more systematic fashion.

- Finally, the County will implement an array of service models that will offer a continuum of best practice approaches to meeting the mental health needs of children in the child welfare system, drawing on scientific literature, consultation with the Panel and other experts, and analysis of data relate to service needs. All of these activities will need to be supported by development of a flexible and shared approach to funding that includes Title IV-E EPSDT, County General Funds, and the Mental Health Services Act.

Plan Modifications

I. Screening and Assessment of Class Members

A. Issue Requiring Response

The November 6, 2006 Order of the Court calls for the County to provide a description of how the County Plan is modified to conduct mental health screening, and assessment when indicated, of all class members, consisting of new entrants into the child welfare system, including a) detained children and youth and b) class members who have not been removed from their homes as well as children already receiving child welfare services.

B. Corrective Action

Determining the Mental Health Needs of New Entrants into the Child Welfare System

As an example of the volume of child maltreatment investigations initiated by DCFS, the April 2007 DCFS Fact Sheet reports that 12,470 children received an in-person response during the month. On average the Department detains approximately 7 percent of youth for whom an investigation has been conducted. A large portion of those youth who are detained are placed with relatives or other temporary parent surrogates, and their cases are handled as Family Reunification cases, including Voluntary Family Reunification (VFR). The most recent DCFS Fact Sheet (April 2007) indicates that almost 10,000 children are placed on a Family Reunification status.

A significant number of children and families are the subject of a child abuse or neglect investigation each month which does not result in the removal of the child(ren) from the home. Of the over 38,000 children currently receiving child welfare services from DCFS, 10,856 are classified as Family Maintenance (FM) cases. As with Family Reunification, some of these cases are handled on a voluntary basis and others are court-ordered.

Family Preservation Services are often offered by DCFS to those families that are the subject of VFM and FM services from the Department. Currently, approximately 2,200 families, including 6,500 children, receive Family Preservation Services. About 40 percent of these families are referred for mental health services.

Approximately 55 percent of children in FM and Voluntary Family Maintenance (VFM) cases currently are served by a Family Preservation Lead Agency. There is also a process in place that refers children identified as needing mental health services to a Family Preservation mental health provider at the time of the Multi-disciplinary Case Planning Conference (MCPC).

The original County Plan provided that detained youth would be seen at one of six Medical Hubs for medical evaluation and mental health screening, using the California Institute for Mental Health (CIMH) Mental Health Screening Tool (MHST) or that, in those instances when such services were not available as the Hubs were implemented, children would be screened via a Team Decision Making (TDM) meeting at the Regional Office. While the medical Hubs are not yet fully operational a recent report (Hub Medical Visits Report, April 2007) indicate that 75 percent of the detained children were seen at one of the Hubs.

The additional requirement of screening for the large numbers of new entrants into the system who are not detained presents a substantial challenge to the continuation of this strategy. As a result, DCFS proposes to gradually transfer the responsibility for conducting mental health screenings of new entrants into the system from the Hubs to the case carrying social workers via a phased process across the Regional Offices. These social workers will conduct the mental health screening as a routine part of their initial casework related to their investigation. They will use the same CIMH MHST now employed by Hub staff. This tool was developed for use by non-clinicians, requires little formal training to use, and can be completed within a short period of time.

With the implementation of Point of Engagement, there is a concerted effort to safely maintain children in their home, wherever possible, with supportive services through voluntary family maintenance, voluntary family reunification or court ordered FM. As such, the County intends to modify the County Plan to include mental health screenings, and any necessary mental health assessments and treatment for all newly opened VFR, VFM, or FM cases where the children are determined to be EPSDT eligible.

Children will be identified for mental health screenings using the following process.

- Initially child welfare referrals received at the Child Protection Hotline will be directed to one of the DCFS Regional Offices for further investigation.

- The assigned Regional Office social worker Children Social Worker (CSW) will conduct a thorough investigation per current regulations and guidelines. All cases resulting in a voluntary disposition will receive a mental health screening, using the CIMH mental health screening tool, by the Emergency Response Social Worker.

- All mental health screenings will be filed in the child's case record and at the same time a copy of the screens will be referred to co-located DMH staff for follow up. A standardized DMH referral and tracking form will be self generated and printed off of the Child Welfare Services Case Management System (CWS/CMS) with the available case information, and the DMH staff will arrange to consult with the current CSW and follow up with additional assessment and treatment services.

- Initially additional screening capacity will be added by calling upon Corrective Action
- CSWs in Service Areas 1, 6, and 7 to conduct mental health screenings of Medi-Cal eligible children and youth when their investigation does not result in a detention, but rather in a VFR, VFM, or FM case. For these

three service areas, there are approximately 6,000 such cases per year, or about 500 new cases per month.

- All such screening results, whether positive or negative, will be provided to the DMH co-located staff in the Regional Offices. The co-located DMH staff will be responsible for reviewing the mental health history of all children receiving a mental health screen and following up with the CSW when the mental health history is inconsistent with the findings of the MHST. When it appears, based upon the findings of the mental health screen or the child's mental health history that mental health services may be warranted, the child will be referred for an assessment with a specialized foster care mental health service provider.

- Phase Two of the County Plan will provide for countywide mental health screening capacity of all new entrants into the child welfare system, and during this expansion of the program, a plan will be initiated to gradually transfer the responsibility of these screenings from the Hubs to the DCFS social workers.

It should be noted that this proposal has yet to be approved by the DCFS employees' union and it may encounter resistance related to workload issues. The County will make every effort to work with the union to resolve any issues that may arise in this regard.

Hub Mental Health Screening

The completion of the mental health screening is currently an integral part of the Medical Hub Program. All newly detained children who are required to have an initial medical exam and, if needed, forensic evaluations, at one of the Medical Hubs, also receive a mental health screening. Currently, Medical Hub staff complete the CIMH MHST, and the results are provided to the CSW or Public Health Nurse (PHN) that initiated the Hub referral, as well as the co-located DMH staff.

In order to ensure that the children with positive mental health screens are assessed by DMH, the Departments have proposed a process whereby the CIMH screening results are received at a centralized location in each DCFS Regional Office where DMH has co-located staff available. It is proposed that a designated DCFS clerical staff in each office will pick up the CIMH MHSTs, along with the medical documents, from a dedicated fax at the PHN workstations. The clerical person will identify the current CSW and deliver the documents to the appropriate Supervising Children Social Worker (SCSW) unit, with copies of the mental health screening results delivered to centralized DMH co-located staff. DMH co-located staff will pick up the CIMH screens and consult with the CSWs.

All children with positive indicators for mental health problems on the CIMH MHST will receive ongoing follow-up to determine if there is a history of current or previous services within DMH, If child is currently receiving mental health services, the co-located staff will consult with the mental health provider and the CSW to coordinate planning and ensure communication around the child's case plan, including Multidisciplinary Assessment Teams (MATs), AB 3632, MHSA FSPs, outpatient services, or acute inpatient treatment, as well as the new intensive treatment service options. Both Departments will work together so that appropriate treatment providers and partners participate in TDMs, and other important case planning meetings with the CSW, caregiver, child and family.

If there are positive indicators on the MHST and mental health services are not in place, the co-located staff will arrange to meet with the CSW, gather other current information regarding the child's current placement and functioning, and link the child for a mental health assessment with a MAT provider or, if a MAT provider is not available, with a directly-operated provider, EPSDT contract provider, or the Enhanced Specialized Foster Care Program.

In addition to this strategy, the County is pursuing a number of the specific recommendations contained in the Panel's Sixth Report regarding improvements to provider readiness for maximizing EPSDT billing related to completion of the MAT process. Examples of these activities include development of a series of documentation vignettes, consideration of an interim treatment/case plan, and a demographic analysis of the population of children and youth who have received MATs.

DCFS, DMH, and DHS, in compliance with both the County's strategic plan to improve the well-being of children and families of Los Angeles County through the coordination, collaboration and integration of services, and the Federal mandate for the provision of mental health assessments and services, developed the MAT concept. Approved by the Board in 2004, these Departments implemented MAT teams through selected DCFS regional offices located in Service Areas 3 and 6. EPSDT resources were the primary funding source to support these activities

While not a specific requirement of the Katie A. settlement agreement, the MAT concept was developed as a collaborative effort among DCFS, DHS, DMH, and other community providers. This process, which has been endorsed by the Panel, is regarded as the most comprehensive and appropriate assessment strategy for children who are removed from their homes. The concept has been modified since its inception to reflect the Departments' commitment to family-centered and strength-based practices. The assessment team model anticipated the participation of the family in the assessment process and the utilization of

team decision-making. The provision of community-based services was a commitment to providing services in a manner that is most conducive to achieving permanency and optimal stability for the child in the least restrictive setting. Services are intended to be responsive to the strengths of the child and family as well as meet the specific service needs.

Each child placed in out-of-home care in this pilot program receives a multidisciplinary assessment. The comprehensive assessments consist of mental health, as well as medical, dental, developmental and educational evaluations, and review of records, the results of which are compiled in the MAT Summary of Findings.

In the context of a case conference, these findings are shared and discussed with the CSW and other family team members, including the parents and appropriate parent supports to identify and confirm the strengths and needs of the child.

The County proposes to expand the MAT program from it's current implementation in Service Areas 3 and 6 to Service Areas 1 and 7 over the course of Fiscal Year (FY) 2007-08 and then to expand MAT services countywide during FY 2008-09.

Determining the Mental Health Needs of Children Already Receiving Child Welfare Services

For those children who have entered the child welfare system the Departments propose to use a two-pronged approach to determine mental health service need.

For children not already identified by the mental health system, DCFS will use a set of functional triggers to identify children who may be in need of mental health services. The County and the Panel will work together to identify the specific triggering events that will generate an automatic referral to DMH co-located staff. Examples of potential triggers are, multiple placements within a short period of time, hospitalizations, and injuries received while in care. These events will be tracked by DCFS using existing information fields in the DCFS database and will be shared with DMH co-located programs for follow up.

The question of service needs for children already identified by the mental health system will concentrate, at least initially, on children served by high level residential placements. DCFS Resource and Utilization Management (RUM) staff will be trained in the use of the Child and Adolescent Needs and Strengths (CANS) tool and will administer this tool to those children and youth from Service Areas 1, 6 and 7 Regional Offices placed in psychiatric hospitals, Community

Treatment Facilities (CTFs), and Rate Classification Level (RCL) 12 and 14 programs. The tool will be re-administered at no less than six-month intervals.

The results of the CANS will be shared with the DMH co-located staff, and the case carrying CSW and treatment and placements needs will be reviewed via the RMP described in Section II in this document.

Additionally, the Panel has suggested that the County conduct spot studies to guide decision-making regarding the mental health needs of various populations of children served by DCFS. The County agrees with this approach and will first conduct a study of approximately 250 VFM, VFR, and foster children to determine the level of mental health needs, or "standard of need" within these populations. The intent of such a study is to gather data to be used to inform future planning regarding service needs and service provision. The County will work with the Panel to design and implement the study.

C. Estimated Human Resources and Funding Requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

Multidisciplinary Assessment Team (MAT) and Related Treatment

Additional EPSDT and match dollars will be needed to support MAT implementation for all detained children as well as the cost of providing mental health treatment for those children who are identified as needing such services. Expansion of MAT activities countywide for children who are initially detained through the DCFS Emergency Response Units and Emergency Response-Command Post is anticipated to involve approximately 6,900 children and families annually. Reimbursement costs to complete these MAT Assessment Services are estimated at a cost of $2,500 per case and will require an estimated $17,160,000. These costs are proposed to be offset by $13,728,000 in EPSDT dollars including a $1,005,000 local match requirement, with an additional $3,432,000 in County General Fund dollars which will not be reimbursable by EPSDT.

DMH is estimating that approximately 70 percent of children assessed via the MAT process will require mental health treatment at an average cost of $3,500 per case. Based upon these projections, the costs are estimated at $16,818,000, including $1,231,000 of County funds as the local match.

The assignment, tracking, and management of these of countywide MAT activities in the 18 DCFS Regional Offices will require 14 additional DCFS MAT Coordinators at the Children Services Administrator (CSA) I level to support the Regional Offices as well as a CSA II and Senior Typist Clerk to oversee the countywide operations. DMH will need to provide a support team for each Service Area to coordinate the mental health assessment and treatment elements of MAT in cooperation with DCFS. For this purpose DMH needs a Clinical Psychologist II, a Mental Health Services Coordinator II, and a Staff Assistant II for each of the eight Service Areas as well as a Senior Mental Health Counselor R.N. and Senior Typist Clerk to provide centralized oversight and quality improvement support. These dedicated MAT staff will operate in conjunction with the co-located staff and the RMP teams described in Section II in this document.

The MAT program is currently operational in Service Areas 6 and 3, though staff support for both DMH and DCFS has not previously been allocated. As noted, the initial expansion of the MAT program for FY 2007-08 will add Service Areas 1 and 7, each containing two DCFS Regional Offices, with the remaining Service Areas to be included in the following FY.

Mental Health Screening and Referral for FM, VFM and VFR cases

To support the mental health screening and service navigation process for children with FM, VFM, and VFR cases for the initial implementation of this process in Service Areas 1, 6, and 7, DCFS and DMH need additional staffing.

DCFS will require clerical staff to support the collection and coordination of information relating to screening protocols, including one Senior Typist Clerk for each Regional Office in Service Areas 1, 6, and 7, a total of eight such positions.

DMH needs clinical staff positions to receive and review the results of the mental health screenings and link children and youth to appropriate mental health assessment and treatment services. These additional staff positions include one Clinical Psychologist II position for each Regional Office in Service Areas 1, 6, and 7, with the exception of Wateridge which will require two such positions – a total of nine such positions.

Additionally, DMH needs one Senior Typist Clerk for the DMH Child Welfare Division to provide centralized support and tracking of the screening and referral process.

Mental Health Assessment and Treatment for VFM, FM, and VFR Cases

To provide mental health services to all the additional children identified with mental health needs who are not referred to Family Preservation will, however, require some proportional expansion of EPSDT dollars to meet the additional demand. EPSDT expansion and related match dollars will be required to cover that percentage of children with Medi-Cal who are not currently being referred to a Family Preservation Lead Agency.

For Service Areas 1, 6, and 7, the Departments are estimating that approximately 850 clients who would not otherwise be identified and served through existing resources would be identified through this process. At an estimated mental health assessment and treatment cost of $3,500 per case, the total amount of EPSDT funds to provide these services would be $2,975,000, including a match (7.32 percent) of $218,000.

D. The County official with direct responsibility for the action

The DCFS Office of the Medical Director, Dr. Charles Sophy has responsibility within DCFS for the development of necessary policies and procedures and related oversight of its Department's interface with the HUB program.

The DHS Special Programs Office has the responsibility of operating the medical program, developing and expanding capacity at across the County and tracking services provided at each Medical Hub.

The DMH Deputy Director, Sandra D. Thomas in collaboration with each Service Area District Chief has responsibility to establish and monitor a system that can follow-up, link and track those children with a positive CIMH screen, and to ensure they appropriately receive an assessment or referral to a mental health provider.

E. Expected outcomes

The services described in this part of the Corrective Action Plan are expected to achieve the outcome that 100 percent of class members receive a timely mental health screening. Additionally, those who may need further assessment and treatment will be referred for these services in a timely manner and a mechanism to track and report on these services will be provided.

F. Projected date for commencement of and completion of the activity

Preparation and implementation of this element of the Plan will commence immediately following approval by the Board of Supervisors, initially focused on

implementation activities in Phase One Service Areas. The Departments anticipate that full implementation in these Service Areas will be achieved by August 2008. Countywide implementation will occur in Phase Two of the Plan.

G. How the activity relates to specific obligations of the settlement agreement

The activities described in this section of the Corrective Action Plan are consistent with the County's obligations under the settlement agreement to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

II. Provision of Intensive Home-Based Mental Health Services as Alternatives to Group Home Care

A. Issue Requiring Response

The November Order of the Court requires the County to provide a description of how the County Plan is modified to:

a) Provide intensive in-home mental health services to the approximately 1,500 class members in congregate care;
b) Explain how the County will modify existing services to the children already receiving intensive mental health services;
c) Explain when and how children in group care will be transitioned to family or home-based settings; and
d) Provide for home and community-based intensive mental health services, as alternatives to congregate care, especially for children who are ages 12 and younger and those placed in RCL 12 and above facilities.

B. Corrective Action

The County is proposing to initiate a multi-departmental, integrated approach to identifying, coordinating and linking appropriate resources/services to meet the needs of children currently in a RCL 6 through 12 facilities. This process will be

referred to as the RMP. The RMP will utilize the DMH Intensive In-Home Mental Health Services programs, including Multidimensional Treatment Foster Care (MTFC), Multisystemic Treatment (MST), and the Comprehensive Children's Services Program (CCSP), and DCFS's intensive services, including Wraparound, Intensive Treatment Foster Care (ITFC) and RCL 6 and above group home care.

Resource Management Process Guiding Principles

The RMP will operate consistent with the following guiding principles:

a) Solutions generated by the family within a team meeting are more likely to succeed because these solutions are based on the unique strengths, needs and preferences of the family.
b) Families are the experts on themselves.
c) All families have strengths.
d) Families can make well-informed decisions about keeping their children safe when they are supported.
e) Families and friends can provide love and caring in a way that no formal helping system can; Members of the family's own community add value to the process by serving as natural allies to the family and experts on the community's resources.
f) Families are capable of change.
g) An appreciation of cultural diversity is crucial to understanding the family and the choices they make about their family.
h) Families leading/involved in the decision-making and case planning process are likely to have better outcomes than families who have decisions made for them.

The RMP will consist of four major elements. First, it will enhance the TDM process for children experiencing a potential placement move to a RCL 6 through 12 placement. Second, the child's strengths and needs will be assessed using the CANS tool by a Resources Utilization Management (RUM) staff member. Third, the family will be informed of the services available to them and will participate in the RMP process. Fourth, the services identified by the family and the team will be approved and linked by a team member and the CSW.

The RMP will be phased in starting in Service Planning Areas (SPA) 1, 6, and 7, but eventually will be countywide (please see implementation section). Additionally, the RMP will provide reports to be used to monitor the utilization of available resources identify resource gaps and track outcomes.

Key components of the Resources Management Process

The RMP will include the following key components:

a) A single referral form from the referring worker that is accepted by all DCFS services.
b) The TDM team will have all the appropriate information, assessments to make timely and responsive decisions.
c) A single group of knowledgeable people who can assist the referring worker make the best placement/referral decision.
d) A standardized assessment tool, the CANS, to guide the decision about the most appropriate, least restrictive level of care needed.
e) The family will be present and have voice and choice in determining the best service option for their family.
f) Services will be timely and responsive to the strengths and needs of the family.
g) The RMP team members will have the responsibility to identify and "authorize" a service for DCFS programs.
h) Ongoing quality assurance and outcome tracking.

The Child and Family Services Referral Form

The Child and Family Services Referral form, formerly referred to as "the Unified Referral Form" was created to simplify the referral process for a CSW. It combines the referral form for TDM and the referral forms for Wraparound, System of Care (SOC), child care, mentoring and the above mentioned DMH programs. Additionally, it is now on CWS/CMS so when a child's information is inputted into CWS/CMS, the Child and Family Services Referral form is automatically populated. Lastly, the form is a "family friendly" form, which means if a family has more than one child, the CSW does not have to fill out separate referral forms for each child.

Assessments and Information

The RMP will be integrated into the TDM process, so whenever a child (who is currently in a RCL 6 through 12 placement or at risk of such placement) is identified as being at risk of a placement move, the CSW will call for a TDM. The process will follow the current TDM policy by which the child's family, support people, and treating agency staff will be invited to attend.

In order for the RMP to be effective, the information provided at the TDM is crucial. Thus, the RUM staff will be responsible for conducting the CANS before the TDM and will discuss the results of the CANS at the TDM. The CANS will help inform the decision about the level of intensity of services and/or the level of

placement. The RUM staff person will also be responsible for bringing to the TDM a current list of all services and placements in the County. If the decision is to place the child, it will be within the family's community, as appropriate. Once a service/placement is identified, the RUM and assigned DMH staff will support the CSW with the recommended service/placement. All Structure Decision Making (SDM), MAT, education, medical and other relevant information will also be provided at the TDM to make the best possible decision.

Composition of the TDM

The membership constellation of the TDM will remain virtually the same as described in the TDM policy (family, youth, family/community supports, etc.). The RMP will require a RUM staff to be involved at all RCL 6 through 12 replacement TDM meetings. The TDM policy will provide the additional guidelines for other attendees.

Family Voice and Choice

One of the most significant outcomes of TDM has been the response from the families and the community about how DCFS is reaching out to change how it conduct business and how it is looking to make better decisions. By honoring and supporting the family's voice at TDMs, the Department is creating a transparent process for providing safety and resources for children. This process will take TDMs to the next level by providing families information about the types of services available and working with the family for the best fit.

Timely and responsive services

By using the CANS in combination with the TDM process, the child and family's strengths and needs will drive the decision and the referral. This will increase the likelihood of service effectiveness and family participation. Additionally, by having the RUM and DMH staff ensures the decision at the TDM is followed; it will cut down on the number of subsequent referral meetings for the CSW.

Service Authorization

In addition to reducing the paperwork and linkage work for the CSW, the RMP will shorten the timeframe to services for the family. Currently, a CSW attends the TDM and then must fill out another referral form for the service recommended in the TDM. They then need to attend a subsequent meeting to determine if the child meets referral criteria.

The RMP will not only eliminate the need for additional referral forms, but will also eliminate the second "screening" meeting. The TDM will "authorize" service

so the CSW will not need to attend another meeting for approval. Additionally, no services can be provided without going through the RMP. The DMH Intensive In-Home Mental Health Services will require a parallel process, integrated into the RMP via the DMH staff member, to provide authorization and enrollment through the DMH Child Welfare Division for tracking purposes.

This process marks a significant change in how DCFS currently provide services and place children in group homes. No group home placement of RCL 6 through 12 will be made without going through the RMP. Currently, when a child needs to be placed in a group home, the CSW's ability to find a placement is driven by what is available, rather than what is a good match for the child. As a result, children are placed in homes that may be long distances away from their family and community, the placement is not a match for their culture, strengths and needs, which leads to placement disruptions and poor outcomes. Additionally, the RMP should facilitate placements closer to family members.

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

The RMP marks a significant shift in the current placement process employed by DCFS and will require management and staffing support. Therefore, DCFS needs an addition of 17 RUM staff (13 CSW positions, 2 Supervising Children's Social Workers (SCSWs), a Staff Assistant II, and a Senior Typist Clerk).

The RUM staff will be assigned to each DCFS Regional Office (the larger offices will require more than one per office based upon TDM data and resource needs).

DCFS will also contract for consulting services at a cost of approximately $50,000 to help develop the placement level algorithm and provide ongoing CANS and RMP training and consultation in the development and implementation stages.

The Staff Assistant II (SA II) will collect the data to track and monitor the RMP. The SA II will also collect consumer satisfaction surveys from the families and staff involved in the RMP. The SA II will produce quarterly reports for regional office and administration planning. Additionally, an annual report will be generated to identify outcomes, data and recommendations.

DMH will utilize existing co-located staff in Service Areas 1, 6, and 7 to support the RMP but will require clinical staff in these offices as well as in the remaining

service area offices to support this new program. DMH needs an additional 13 Clinical Psychologist II positions and 2 Senior Community Mental Health Psychologists for this purpose. These staff will be added to the DMH co-located mental health teams in the DCFS Regional Offices and report up through the local Service Area administrations. They will be hired and deployed in concert with the rollout plan described below.

DMH also needs a Mental Health Services Coordinator II and a Senior Typist Clerk position to provide centralized enrollment of the intensive in-home mental health services. These two staff positions will be centralized under the DMH Child Welfare Division.

DMH has already allocated three Clinical Psychologists II positions to support the implementation of the Intensive In-Home Mental Services programs. At this time DMH will need a Senior Community Mental Health Psychologist position to supervise these three staff members and the two staff members needed for centralized enrollment. This position will also be available to represent DMH in countywide discussions regarding the RMP and for support of the mental health services related to the ITFC program being established by DCFS.

DMH does not anticipate that the staff needed to support the RMP will be able to be entirely supported with EPSDT given the nature of the job duties and estimate that approximately 50 percent of this cost will need to be supported with another source of funds.

D. The County official with direct responsibility for the action

In addition to DCFS Medical Director Dr. Charles Sophy and DMH Deputy Director Sandra D. Thomas, DCFS Deputy Director Lisa Parrish and DCFS Division Chief Michael Rauso, along with DMH District Chief Gregory Lecklitner will have primary responsibility for this action.

E. Expected Outcomes

The Departments anticipate that the RMP will achieve the following outcomes:

a) Increase the clinical effectiveness of the services.
b) Increase the number of children placed in their own neighborhoods, communities and schools, in the most appropriate, least restrictive setting.
c) Reduce the number of re-placements of children.
d) Decrease the lengths of stay of children in out-of-home care.
e) Decrease the number of children re-entering out-of-home care (safety).
f) Increase the number of siblings placed together.
g) Increase the number of families using community-based services.

h) Increase the community's involvement in partnering with the child welfare system and increase the community's capacity to offer supportive services.
i) Decrease the time to when a family receives services.

F. Projected date for commencement and completion of the activity

The initial planning for the RMP began in April of this year, and it is anticipated that this process will be completed by September, with implementation of the RMP to follow in four stages.

The first phase of implementation (October - December) will take place in the eight Regional Offices located in Service Areas 1, 6, and 7. The Resources Management Process will start with all RCL 10 and above children currently in out-of-home placement and who are identified within 60 days of being discharged (the identified children will not have a seven-day notice). This will allow the RUM staff the ability to practice doing the CANS and gather all the needed information to make the process effective. All CANS information will be gathered and compared with the decision of the team and then tracked for consistency and outcomes.

During the second phase of implementation (December 2007 – February 2008), the original three Service Areas will fully implement the RMP for the original offices and replacement TDMs for children in a RCL 6 or above placement. Additionally, five new DCFS Service Area offices will be identified to start the RMP.

In the third phase of implementation (February 2008 - April 2008) the additional five Service Area offices will fully implement the RMP.

For the fourth phase (April 2008 - September 2008) all DCFS offices will be fully operating the RMP and an evaluation of the process will be conducted. The evaluation will not only identify the strengths and needs of the current RMP, but will identify system service gaps and needs in addition to the effectiveness of the algorithm.

G. How the activity relates to specific obligations of the settlement agreement

These activities are consistent with the four major objectives of the settlement agreement, including the County's obligation to ensure that class members:

a. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;

b. Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c. Be afforded stability in their placements, whenever possible; and
d. Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

III. Provision of Mental Health Services to Children in Foster Family Agencies

A. Issue Requiring Response

The Finding of Fact and Conclusions of Law issued by the Court also calls for a description of how the County Plan is modified to provide for the mental health needs of children and youth placed in Foster Family Agencies.

B. Corrective Action

The initial activity, essential to all subsequent activities of this section, is to identify those children who are placed in foster family agencies. Obtaining this information from DCFS will enable DMH to determine those children who are already receiving mental health services, but for who enhanced and more intensive treatment services may be necessary. Also, this essential data exchange will enable DMH to determine those children who are not linked to mental health services currently, and for whom more active outreach and engagement is necessary to ensure their appropriate participation in treatment.

The initial data exchange must include the name, date of birth, social security number, address, and telephone number of the caretaker. Phase One will be limited to those children placed in foster family agencies in Service Areas 1, 6, and 7. The remaining five Service Areas of the county will be included in Phase Two of the Plan. This data exchange can be accomplished by utilizing existing staff and resources.

Within 60 days of receipt of the data from DMH, DCFS will provide a list of identified children who are receiving mental health services in Service Areas 1, 6, and 7. Upon receipt of these data, DCFS and DMH will jointly evaluate the treatment plans, goals, and objectives of those children linked to mental health services, through the convening of TDM case conferences, or other evaluation tools and methods within the scope of practice of DCFS and DMH staff to determine if the treatment plans and strategies require revision and enhancement.

Screening

To address the mental health needs of those children who are either 1) not currently receiving mental health services or 2) are proposed for a new placement into an FFA, the following activities are to occur.

The CIMH MHST will be administered to all newly placed children in FFAs within 60 days of admission. For existing FFA placed children who have not previously been screened, the CIMH MHST, which takes approximately 5 to 10 minutes to complete, will be administered by the CSW at their required monthly visit to the child.

It should be noted that the CIMH MHST may also be administered as part of any TDM, RPRT, or RUM Case Conference involving any FFA placed child, to identify unmet mental health treatment needs. The expected outcome is that crisis and/or potential disruption of placements provides another vital opportunity to screen and possibly assess for additional mental health services and supports. This activity will be accomplished utilizing existing staff and resources. However, the review and analysis of the results of the screenings and subsequent linkage activities to ensure timely referrals for assessments or other comparable will require additional staff and funding, the specifics of which are largely unknown at this time and will be determined by the results of the screenings on a large scale basis.

Assessment and Treatment

All FFA placed children who demonstrate positive indicators on the screening will be referred to the DMH co-located staff in the Regional Office where the CSW is assigned. The DMH systems navigators will arrange for all children and youth with a positive mental health screening to be referred for a mental health assessment, which will commence no later than within 30 days of the completion of the screening..

Upon receipt of completed mental health assessments, DMH will facilitate referrals for appropriate levels of mental health treatment of FFA placed children, based upon the results of the assessments and verification of the medical necessity for treatment in accordance with State Medi-Cal standards. Treatment will commence within 15 days, or as soon as possible, from the date of the completed mental health assessment recommending treatment.

In addition to this plan, the County wishes to consider a transformation of the way FFAs are used within the County. However, further planning and assistance from the Panel on this particular issue is necessary. Guiding principals for this transformation include the County's desire to incentivize existing FFA families to

adopt the children they are currently caring for, a rethinking of how FFAs are used to serve children (and what kind of children are served thereby), and exploring the State's willingness to allow the County to require FFAs to accept more case management responsibility for the children in their care (thereby freeing County staff and resources to reduce case loads and intensify services elsewhere).

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

As noted above some of the activities described can be accomplished utilizing existing resources within DCFS and DMH. However, at this point many of the estimated costs are unknown and will only be determined by completion of the data exchange, matching, screening and assessment tasks. Upon completion of those tasks, at least in the three initial Services Areas 1, 6, and 7, DMH and DCFS will better be able to project the estimated costs of addressing the needs of 1) FFA children not currently receiving any mental health services; and 2) FFA children who are currently receiving treatment but for whom more frequent and intensive services are indicated.

DMH will require additional staff positions for the co-located mental health programs in DCFS regional offices to support the handling of the CIMH screening tools and provide the necessary linkage to assessment and treatment services. DMH estimates this staffing need to be one additional Psychiatric Social Worker II for each of the 16 DCFS regional offices. These positions will be integrated into the DMH co-located programs that report to the DMH Service Area administrations.

Absent reliable data, DMH estimates that each FFA child may require approximately $8,000 dollars per year of mental health treatment services, including the cost of the initial assessment. These figures are greater than the current average cost of care for all children and youth receiving mental health services in Los Angeles County, but less than the estimated costs per annum in serving children in the most intensive types and levels of care such as Wraparound and Full Service Partnerships, currently projected at approximately $15,000 per year per child. For planning purposes, the County proposes a figure of $8,000 per year per child for mental health treatment services.

According to a study of 608 children placed at Los Angeles County FFAs done by Dr. John Lyons in 2006, 32.8 percent of the sample had no behavioral health

needs, while 49 percent of the sample had at least a behavioral health need requiring watchful waiting or prevention efforts. Twenty-five percent of the sample had a need level requiring actionable or urgent response. Only 10.6 percent of the sample had behavioral health needs meeting the eligibility criteria for Treatment Foster Care used by Philadelphia.

If the FFA caseload is currently approximately 6,000 children and assuming that 25 percent will yield positive screenings and assessment that recommend more intensive services, the estimated costs for the entire caseload could be approximately $12,000,000 (1,500 children x $8,000 per child) per year. But because DMH does not know what it costs now to serve those that are already engaged in treatment, the Department does not know what additional funding resources will be necessary to address the needs of these children. If we estimate, for planning purposes, that half of those children in need of services are already receiving appropriate services, DMH will anticipate that additional treatment costs will be about $6,000,000 of EPSDT, requiring a match of $439,000.

DMH also needs a Psychiatric Social Worker II position as well as a Staff Assistant II to support the collection and reporting of information related to the provision of mental health services to children placed in FFAs. These two positions will report centrally through the DMH Children, Youth, and Family Services Bureau.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. They will be supported by DCFS Deputy Director Lisa Parrish and DMH Acting Deputy Director Paul McIver.

E. Expected Outcomes

The expected outcome of this activity will be to identify the actual need for treatment among the FFA population of children through use of a standardized screening and assessment process. Additionally, this process will provide a baseline or benchmark by which measurement of future progress in addressing the mental health needs of FFA children may be assessed.

F. Projected date for commencement and completion of the activity

This activity will commence upon approval of the Corrective Action Plan. Initially, the focus will be on children placed in FFAs in Service Areas 1, 6, and 7, but given that the entire FFA population numbers over 6,000 children, 1,100 of whom

are placed in facilities outside of Los Angeles County, the Departments expect that completion of the screening for all FFA children could be completed within 12 months of commencement. Beyond this initial screening process, ongoing screenings of newly placed children into FFAs would be ongoing.

G. How the activity relates to specific obligations of the settlement agreement

The specific objective of the settlement agreement addressed by this action is that class members shall receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.

IV. Provision of Mental Health Services to Children Placed in D-rate Homes

A. Issue Requiring Response

The County is to provide a description of how the County Plan is modified to provide "new" intensive in-home mental health services to approximately one-half of the children placed in D-rate homes.

B. Corrective Action

In addition to the intensive in-home service models proposed in the original County Plan, the modified plan will call for the development of a specialized foster youth and family support team, to operate within each DCFS Regional Office as part of the co-located mental health team. This unit will provide 24/7 crisis response and stabilization in those instances when a DCFS-involved child's behavior threatens the current placement. The unit will also employ the guiding principles of Treatment Foster Care, such as foster parent training to prevent and address difficult child behaviors, responding to problem behaviors before they escalates to the point where the placement must be changed, strength-based assessment and interventions, use of a team approach with the foster parent or family member as a key member of the team, the use of parent/foster parent supports, and regular tracking of youth behaviors and family stress levels.

Initially these services will be targeted to those youth placed in D-rate homes and their foster parents with services to be extended to family maintenance and family re-unification cases once the initial teams have sustained implementation and demonstrated a reasonable degree of success.

The youth and family supports teams will consist of a program supervisor, a child therapist, a parent trainer, a parent advocate, a part-time psychiatrist, clerical staff members, and a skills trainer. The teams will be supported and overseen by a mental health program heads that will be responsible for coverage of four Regional office teams. The teams will work closely with the DCFS and DMH D-

rate staff to identify children and families most in need of service. DMH will consider utilizing a version of the MTFC Parent Daily Report, modified to be used to track child behavior and foster parent stress on a regular basis as one means to identify such children and families and initially will target those families where the child's behavior threatens the stability of the placement, including those cases where a seven day letter has been filed. The teams will also provide ongoing stabilization services for those D-rate children referred to the DMH Psychiatric Mobile Response Teams (PMRT) who are found not to require psychiatric hospitalization.

The program will also provide foster parent training and support and will consider the use of the Incredible Years parent training program as part of this effort. DMH anticipates that services will be intensive, but brief in time, reflecting the episodic nature of the problems of children and youth in these placements and is not intended as an ongoing or long-term treatment resource. Children and youth needing such services will be referred to Specialized Foster Care services in the community.

This modified version of our original plan calls for the development of these youth and family support teams in each of the DCFS regional offices located in Services Areas 6, and 7 (Service Area 1 has proposed an alternative crisis stabilization team as part of Phase One of the Plan.) The County will study the success of these services once they have been implemented and sustained for a period of time and will modify their delivery as indicated based upon these studies.

In addition to this new service option, the modified plan will also require that the DMH D-rate case managers include consideration of FSP and Wraparound for each D-rate client at each six month review.

The existing DCFS D-rate Unit consists of eight licensed mental health professionals (CSWs) under the supervision of two licensed mental health professionals (SCSWs). These staff review and forward requests for initial D-rate assessments to DMH. They also review cases every 6 months after D-rate certification. This includes an extensive questionnaire completed by the D-rate foster parents about the child's functioning, services they are receiving and other services the caregivers think are needed. Caregivers are contacted as appropriate for elaboration/clarification. One CSW monitors D-rate children in 2 regional offices.

The existing DMH D-rate Unit consists of a single Supervising Psychiatric Social Worker and five Medical Case Workers (MCWs). The MCWs are co-located in the DCFS regional offices and serve 2-4 regional offices, collaborating with the DCFS D-rate staff assigned to those offices. The MCWs link recently assessed

D-rate minors to needed mental health services. They also participate in the 6-month review of D-rate minors done by DCFS, and check linkage to DMH services and review caregiver feedback on functioning and any mental health services that may be needed since the last assessment/review. This includes contact with the caregivers to check written feedback.

The County is proposing to augment this existing staffing pattern in the D-rate program to improve service delivery to children placed in D-rate homes.

C. Estimated Human Resources and Funding Requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

Service Areas 6 and 7 include six DCFS regional offices, with four of those offices located in Service Area 6 and two offices in Service Area 7. DMH is proposing that each of the DMH co-located programs in these offices be augmented with a crisis stabilization team consisting of a Senior Community Mental Health Psychologist, a Psychiatric Social Worker II, and Clinical Psychologist II, a Senior Community Worker I (Parent Advocate), a Rehabilitation Counselor, a Supervising Typist Clerk, and an Intermediate Typist Clerk.

Additionally, DMH proposes that these teams would share access to a full-time child psychiatrist to be shared between the six offices or, alternatively, that each Service Area hire a half-time child psychiatrist to support the work of the Service Area teams.

These crisis stabilization teams will augment existing DMH co-located staff and report up through the Service Area administrations.

The DCFS D-rate Unit is in need of four additional CSWs. This is primarily to address the need for services of D-rate children living in the Antelope Valley region of Los Angeles County. There are two regional offices in this area. The model of having one D-rate evaluator cover cases in two or more regional offices is difficult to implement in such cases because of the higher caseloads, long periods of travel time, and the relatively sparse availability of services in the area.

Also the current unit staffing pattern is so lean it does not offer flexibility for coverage for staff being sick, going on vacation, and other staff absences or position vacancies.

The DMH D-rate Unit is in need of clinicians and support staff to help improve the delivery of mental health services to children placed in D-rate homes. The SPSW who developed the program and hired and supervised the MCW staff left County employ. She was on an ordinance item and to continue operation of the unit, funding for this SPSW item is needed. This clinician also liaises with the licensed psychologists and social workers who perform the D-rate assessments and with the DCFS licensed mental health professional staff. A PSW II item is also needed to support the functioning of Therapeutic Behavioral Services (TBS) coordination work (liaison with State DMH, TBS providers, tracking provision of services to clients, liaison with the Central Authorization Unit, etc.). The PSW II performing this function has taken another job and was on an ordinance item. The majority of clients served with TBS are D-rate and Katie A. eligible minors. Funding the ongoing function of this item is critical. Another PSW II item is needed to assist the Children's Inpatient Clinical Case Management Unit. The unit provides hospital discharge planning teleconferences for psychiatrically hospitalized DCFS minors, most of whom are D-rate/Katie A. eligible.

One Mental Health Services Coordinator II is needed to staff the DMH D-rate Unit. This person will contact foster parents to verify information and inform them of upcoming D-rate assessments, assign cases to assessors, maintain a database, monitor and track caseload assignments and assessor performance, review returned charts for accuracy and completion and follow up regarding discrepancies. One Senior Typist Clerk is needed to prepare completed assessment charts for review and monitor reviewers' checking out charts, verify accuracy of reviewed charts and return charts with discrepancies, enter units of service, submit provider invoices for reimbursement, data entry in database, make copies of completed assessment charts and transmit to DCFS.

D. The County official with the direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. They will be supported in this action by DMH District Chief Gregory Leckliner as well as the DMH Service Area District Chiefs in Service Areas 6 and 7 as well as DMH Deputy Director Paul McIver with respect to the D-rate augmentation.

E. Expected Outcomes

The Departments anticipate that the develop of these youth and family support teams will stabilize children and youth placed in D-rate homes, preventing their further entry into the child welfare system, reducing placement disruptions, and promoting opportunities for increased timelines for permanency. DMH also expects that this service will reduce the need for higher levels of mental health

treatment, including psychiatric hospitalizations. It is anticipated that the augmentation of the D-rate unit will increase the efficiency of the D-rate program and provide for improved tracking of service delivery and outcomes.

F. Projected date for commencement and completion of the activity

Program design will commence immediately upon approval of the Corrective Action Plan by the Board of Supervisors. DMH anticipates that these directly operated programs will be fully implemented within 12 months of Board approval.

G. How the activity relates to specific obligations of the settlement agreement

This activity is consistent with all four of the specific settlement agreement objectives, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

V. Continued Use of Existing Mental Health Resources

A. Issue Requiring Response

The November 6, 2006 Order of the Court calls for the County Plan to be modified to:

a) Demonstrate how RCL 12 and 14 facilities and Community Treatment Facilities (CTFs) may be the most home-like setting appropriate to the clinical needs of some class members; and
b) Develop sufficient service capacity to provide intensive mental health services, for those class members who need such services, in the most home-like setting appropriate to each class member's need

B. Corrective Action

The Katie A. settlement agreement calls for nothing short of the transformation of the mental health service delivery system for DCFS involved children, youth, and

families. A central element of the settlement agreement is the reduced reliance on congregate care placements, particularly those highest end placements such as RCL 12 and 14 group homes and CTFs and, in turn, the development of intensive in-home mental health services as preferred alternatives.

The County is committed to the development of such alternatives and believes that, for a significant portion of youth now placed in such facilities, intensive in-home services are the preferred option. A recent report on youth placed in these facilities conducted by Dr. John Lyons (Lyons, 2007) found that roughly half of those placed in the setting could be better served in a more home-like environment. At the same time, the County is of the opinion that some youth will continue to require such placement, at least during this transformation period. These placements are not viewed as the clinical ideal, but rather as a temporary point in time best available option. While the County believes that every effort should be made to provide for placement in the most home-like setting, some youth at a point in their dependency careers will have, at least temporarily, exhausted their options in this regard and these higher level congregate care settings will be the only available option. Clearly, however, these placements should not be regarded as long-term and every effort should be made to identify in-home alternative placements for these youth starting immediately at the point of placement. It is the goal of the County to move to a point where group care is utilized only as a brief, episodic resource when a child's clinical needs dictate the need for a highly structured environment that these settings can provide. The Departments will work closely with group care providers to ensure that quality treatment models, appropriate staffing, and attention to client needs and outcomes are developed to support this goal.

At present the County has approximately 50 youth in Community Treatment Facilities and another 843 placed in RCL 12 and 14 facilities. Consistent with the findings of the Lyons report, the County will work to reduce the number of youth in such placements by 25-30 percent over the next three years and will continue beyond this period to reduce the number of children in group care. The key strategies to accomplish this objective are the routine assessment of youth needs and strengths, the establishment of a RMP to evaluate these findings, additional support for children placed in D-rate homes to prevent their penetration into the congregate care system, and the development of intensive in-home service options including Wraparound, Treatment Foster Care, MST, CCSP, and MHSA FSP, which have designated children in the child welfare system and those at risk of entering the child welfare system as one of four focal populations. Overall, these initiatives provide for more than 2000 intensive in-home alternatives to congregate care.

The County will also develop service capacity informed by evidence-based and best practices models such as Treatment Foster Care, Wraparound, and

systems of care. These programs will provide a level of service intensity that is lower than the models from which they are drawn, but significantly more robust than traditional outpatient individual therapy. One of the specific target populations for this approach will be the pre-school infants and toddlers who are placed in group homes and in D-rate homes or who are at risk of such placements. The County will explore intensive intervention models for this population that draw from trauma-focused practices and use such approaches as dyadic therapy addressed to reactive attachment problems related to histories of child maltreatment. DMH will also include significant rehabilitative services within these models. Such services are an important adjunct to clinical service models and can be provided by non-clinical staff that can be recruited from local communities. They will need to be developed within a system that provides for their timely and flexible utilization as an alternative to both more expensive and intensive services such as Treatment Foster Care and Wraparound when client needs assessment indicates that these higher end services are not necessary. These kinds of services will also be used as an alternative to the current use of "hybrid" models that combine residential placement and mental health treatment such as Community Treatment Facilities and RCL 12 and 14 placements. Additionally, the County will be using the RMP described in Section II in this document as a team decision making process linked to considerations of residential care. This will promote the use of non-residential treatment alternatives such as Wraparound and other community-based options.

The County is also developing 80 slots of MST for children in the child welfare system who come to the attention of the 241.1 process, especially those that are placed on dual supervision. DMH contract providers have been identified to develop MST programs and training in this evidence-based practice model has been scheduled for August of this year.

Beyond expansions of these more intensive in-home options that County will also need to review the use of more traditional mental health services for foster youth, including psychiatric hospitalization, crisis intervention/stabilization, day treatment, psychiatric consultation and medication management and self-help and support groups. The County will need to analyze levels of service need, penetration rates for the use of these services across geographical areas, and youth outcomes. Using these kinds of the studies, the County will need to work with providers to alter service delivery patterns to achieve the best possible array of services targeted to those youth and demographic areas most in need.

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in

the Departments' budgets during the Supplemental Changes phase of the budget process.

Resource needs have been described in the separate sections throughout this document relating to each of the programs described above. Additional resource needs will be identified as other model programs are planned and implemented.

At this time DMH needs an additional allocation of EPSDT to augment existing funding for the MST programs. In our initial plan, DMH estimated that each of the intensive in-home mental health programs would require approximately $15,000 per slot. In the case of MST, DMH is now finding that this figure may be somewhat restrictive. Therefore, DMH needs an additional $5,000 per slot of EPSDT, a total of $400,000 to cover the 80 slots, including the required match of $29,000 at 7.32 percent. These additional dollars will allow the MST programs to operate with more flexibility in serving these challenging youth.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. They will be supported by DCFS Deputy Director Lisa Parrish and DMH District Chief Gregory Leckitner.

E. Expected Outcomes

The more intense service models will provide for alternatives to higher end congregate care placement and reduce the numbers of children and youth placed in these settings. The Departments also expect that these services will shorten timelines to permanency, promote stability of placements, and improve safety for youth. Additionally, the Departments expect that these newer service models will result in improved well-being for children, including improved school attendance and academic performance, better relationships with peers and caregivers, and reductions in substance abuse and delinquent behavior.

F. Projected date for commencement of and completion of the activity

Planning for these activities has already begun. In those instances where new funding is required, the implementation of the activities will require authorization by the Board of Supervisors. For such activities, program protocols, policies, and procedures will be initiated upon Board approval and hiring will commence within two months. The Departments anticipate that these activities will be fully implemented within one year of Board approval.

G. How the activity relates to specific obligations of the settlement agreement

These activities are consistent with all four of the specific settlement agreement objectives, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

VI. Expansion of Wraparound

A. Issue Requiring Response

The November 2006 Order directs the County to provide a description of how the County Plan is modified to make Wraparound services available to class members who are in or at risk of placement in facilities of RCL 10 and above and/or who do not have intact families and increase Wraparound slots by no fewer than 500 by June 30, 2008

B. Corrective Action

Under the auspices of Senate Bill 163, the County of Los Angeles has provided Wraparound services to families and their children with multiple, complex and enduring needs since 1998. Wraparound is an integrated, multi-agency, community-based process grounded in a philosophy of unconditional commitment to support families to safely and competently care for their children. The single most important outcome of the Wraparound approach is a child thriving in a permanent home and maintained by normal community services and supports.

The Los Angeles County Wraparound model has been developed through a collaborative partnership between the County and the Lead Wraparound Agencies (LWAs). This partnership, through regular meetings and solicitation of community and family input, maintains high standards, measures the achievement of outcomes and ensures voice, choice and access for all stakeholders.

Enrollment in Wraparound is completed through a network of Interagency Screening Committees (ISC) located in each of Los Angeles County's eight SPAs. There are currently 15 ISC teams. The ISCs conduct "consultations" defined as brief and focused case discussions utilized to make an enrollment decision regarding the case and the services recommended.

NOTE: The RMP is envisioned to replace the function of screening and authorizing referrals at the ISC. Thus the ISC will change to a pure support/monitoring process for Wraparound for DCFS referrals. For referrals from DMH and Probation, a different process will be established.

For enrolled children and families, Wraparound services are provided on a "no eject", "no reject" basis. As the needs of the child and family change, the Wraparound Plan of Care is changed to meet these needs and to achieve identified outcomes.

State eligibility criteria for Wraparound require that the child be placed in, or at risk of placement in, a RCL 10-14 group home.

Wraparound serves children who are under the jurisdiction of DCFS, Probation, and DMH through AB 3632. Wraparound is a community-based process, and referrals are based on the service area where the child and family are to receive services. Referrals are made to the service area and ISC where a family member or caregiver has been identified and has agreed to participate in Wraparound services.

Current Status

On May 1, 2006, the Los Angeles County Wraparound Program entered into its' third phase of expansion, with the addition of 27 new service providers joining the 8 previously contracted providers. There are now 34 agencies in 63 sites within 8 SPAs. With this expansion in the number of providers, Wraparound expected to increase its services to eligible families in Los Angeles County from the 553 families being served at the end of FY 05/06 to more than 1,217 families by the end of FY 07/08 (see chart A). As of March 31, 2007, there were 904 children actively enrolled in Wraparound.

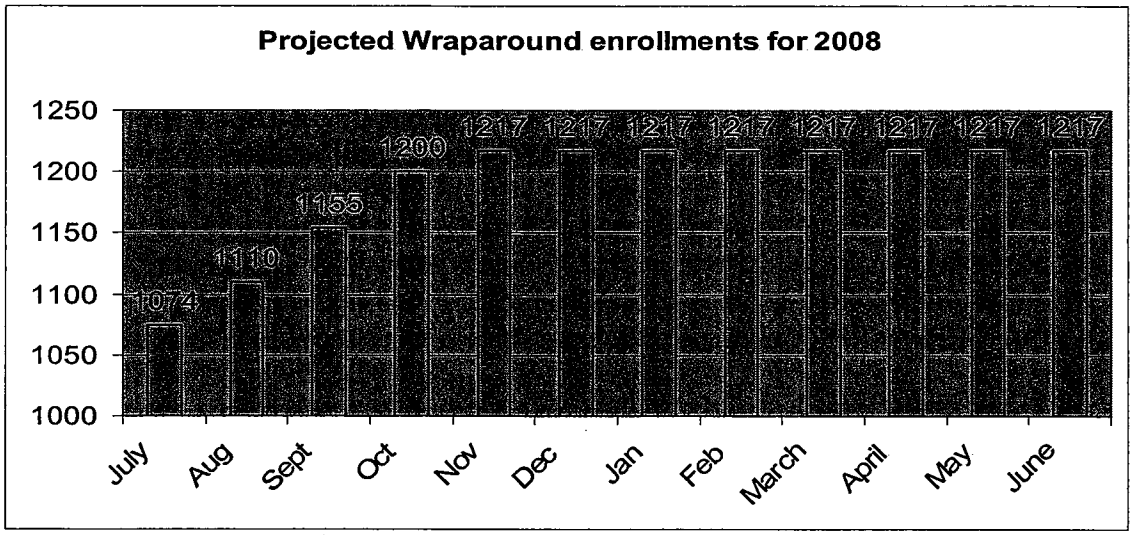

Chart A. shows actual and projected enrollments from July 1, 2007 through June 30, 2008.

Monitoring

To insure our children and families receive high quality Wraparound, DCFS has implemented four levels of monitoring: administrative, programmatic, practice and fiscal. The Technical Assistance and Training Unit of DCFS Wraparound Program currently consists of a CSA II and three CSA I who conduct the administrative and programmatic audits for all of our contracted Wraparound agencies on a yearly basis in addition to their training and technical assistance responsibilities. The administrative and program reviews include a review and analysis of various quarterly and monthly reports submitted by the contracting agencies in addition to site visits.

ISC teams are currently responsible for enrollment and the practice monitoring. Currently, there are 15 DCFS ISC Liaisons who are CSW IIIs who are supervised by two SCSWs (Note: The Liaison staff along with the CSA staff reports to the Wraparound Program Manager, a CSA III). Providers are required to submit a Plan of Care that documents all of the activities/services for each child they serve after the first 30 days of services and then every 6 months thereafter. The ISC teams which is comprised of Liaisons from all three referring Departments are responsible for reviewing the Plans of Care and either approving the Plan, or deferring approval until specific information is provided.

The Los Angeles County Auditor Controller's staff provides the fiscal monitoring for Wraparound. They visit all of the providers and provide the Los Angeles County Board of Supervisors and DCFS' Wraparound administration with reports and recommendations regarding their audits.

In the coming year, the Departments are planning to implement another level of monitoring that will focus on customer satisfaction and Wraparound model fidelity, which will utilize parent partners as the reviewers and use the Wraparound Fidelity Index (WFI) as the tool.

Prioritizing Wraparound referrals from group homes

An internal DCFS document is being drafted to emphasize that the priority population for Wraparound will be children coming from group home care with a secondary emphasis on children at risk of group home care. The document highlights, that all children currently in or leaving group home care need to be assessed for the appropriateness of Wraparound. Additionally, each Regional office is being engaged to share their list of children in group home care with the ISC liaison, so the CSW can be contacted and encouraged to make a referral. Additionally, a workgroup is being formed to address the issue and identify barriers for ongoing prioritization.

C. Estimated Human Resources and Funding Requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

Judge Matz's November 2006 order for an increase of 500 additional Wraparound slots by June 2008 and the expansion of the target population to include RCL 10 will require an increase in the Wraparound infrastructure to support and sustain both growth and quality of services). Increased staffing is needed at both at the ISC level and at the administrative level to handle the growth and to ensure Wraparound model fidelity, timely and appropriate services, administrative compliance with SB 163, training, and compliance with the Wraparound contract.

The increased staff needed by DCFS to support the expansion of Wraparound includes:

a) 7 additional CSW III items for the ISC teams; 1 SCSW to supervise; 2 ITC items to provide clerical support for the new and existing ISC teams. The additional CSW III items will help increase the capacity of the local ISC teams in their effort to monitor, trouble shoot and effectively handle the increase in number of children and plan of care reviews; and

b) 6 additional CSA I items, 1 STC, 1 Staff Assistant II, and 1 Sec III for the Wraparound administration (training/technical assistance/quality improvement). The additional CSA I items will join the current CSA I items and will be assigned provider agencies for their administrative/programmatic caseload reviews. One CSA I will be responsible for maintaining, collecting and providing reports regarding outcomes, demographic information for policy/program review and decision making. The Staff Assistant II will be responsible for maintaining, monitoring and correcting the Wraparound master list to ensure accurate payment to the Wraparound providers. The STC item will be responsible to the CSA II and the Sec III position will be responsible to the CSA III, program manager.

In addition to these DCFS staff, DMH will also need to enhance staffing to support the additional Wraparound slots. The increased staff needed to support the expansion of Wraparound for DMH is:

a) 1 Clinical Program Head to provide program management which includes: serving as the lead manager for the DMH Wrap/CSOC Program (including a Centralized Enrollment Unit housed in the Countywide DMH Child, Youth and Family Division); and coordination of training, technical assistance, consultation, and supervision for the DMH Coordinators;
b) 1 Clinical Psychologist II to provide countywide support for training, technical assistance, and quality assurance support to DMH Coordinators and Wraparound providers-particularly relative to EPSDT Medi-Cal billing issues and revenue maximization;
c) 5 Psychiatric Social Worker IIs (PSW IIs) for the ISC Teams who will help increase client capacity, monitor, trouble-shoot and effectively handle the increased number of children and plan of care reviews;
d) 2 Intermediate Typist-Clerks (ITCs) to provide clerical support for tracking baseline data centrally within the Child, Youth and Family Services Division and the ISC teams;
e) 1 Chief Research Analyst, Behavioral Science to prepare reports and secure program data necessary to monitor quality assurance as well as track, obtain, and analyze critically needed provider claims data on an ongoing basis (this position is currently an ordinance item supported through a federal grant that needs to be a permanent item fully dedicated to the Wraparound and CSOC program); and
f) 7 additional Senior Community Workers - these items are for Parent Advocates (3 countywide and 4 assigned to selected Service Areas) to conduct outreach, client/family engagement, and support program monitoring, and quality assurance)

Judge Matz's order will also necessitate the commitment of additional fiscal resources, specifically to provide the County match for SB 163 (60:40 match) and EPSDT (7.32 percent). The estimated total dollars needed to achieve the 500 additional slots from this point forward is approximately $25,000,000 for the SB 163 match (717 enrollments as of November 2006 plus an additional 500 slots, bringing the total slot capacity to 1,217). The EPSDT costs associated with this increase, including the 7.32 percent match ($530,000), would be $7,236,000. Note that the Wraparound program was previously funded up to 815 slots, so these additional dollars represent only the difference between the 815 figure and the projected 1,217 figure or 402 additional Wraparound slots.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH.

The senior administrators with responsibility for this program will be the DCFS Multi-Agency Services Administrator and Division Chief, Michael Rauso and the DMH District Chief of the Child, Youth, and Family Services, Sam Chan. They will collaborate with each DMH Service Area District Chief who, in turn, has responsibility for establishing and monitoring follow-up and linkage of those children who meet criteria for Wraparound and Children's System of Care and are appropriately screened, assessed or referred to a DMH Provider.

E. Expected Outcomes

Wraparound provides an alternative to higher end congregate care placement settings and is intended to reduce the numbers of children and youth placed in these settings. DCFS expects to continue to see shorter timelines to permanency, more community/family like placements, and improved safety for youth involved in Wraparound. Additionally, DCFS expects Wraparound to continue to achieve improved well being for children, improved school attendance and academic performance, better relationships with peers, caregivers and their community supports, and reductions in substance abuse and delinquent behavior.

F. Projected date for commencement of and completion of the activity

Wraparound expansion is well underway and DCFS expect to reach the target enrollment number of 1,217 well before the June 2008 deadline.

G. How the activity relates to specific obligations of the settlement agreement

Wraparound is consistent with the specific settlement agreement objections, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

VII. Implementation of Treatment Foster Care

A. Issue Requiring Response

The November 2006 Order of Judge Matz requires the County to provide a description of how the County Plan is modified to provide class members with no fewer than 300 Treatment Foster Care slots by January 1, 2008.

B. Corrective Action

The County has decided to develop 220 ITFC slots (beds) with the remaining 80 slots to employ a Multidimensional Treatment Foster Care (MTFC) model. At the present time, there are no ITFC or MTFC programs in Los Angeles County. These two alternative Treatment Foster Care models are described below.

Intensive Treatment Foster Care

ITFC was first authorized in California by SB 969 in 1996 (see WIC Section 18358) and includes the following components:

a) Identification of the population of children to be served (80 percent must be children placed in a group home RCL 12 or higher, and not more than 20 percent at risk of psychiatric hospitalization or placement in a group home RCL 12 or higher);
b) Identification of specific FFAs certified by the county as meeting the ITFC program requirements concerning required personnel, administrative support; and

c) A process whereby all children placed in ITFC programs shall either have completed a level of care assessment indicating a need for services greater than regular foster care or have their placement reviewed by the County's existing interagency review teams (IRTs).

Following is a description of the state ITFC program components. Special attention is given to the selection and training of foster parents, including 60 hours of training for foster parents on the care of emotionally disturbed children, and 12 hours of in service training annually. Training must include but is not limited to: working with abused and neglected children, progressive crisis intervention, and CPR. The initial 60 hours must be completed by at least one parent before any child in placed. The second parent must have completed at least 40 hours prior to placement and the additional 20 hours within the first 6 months. All necessary support services are to be provided to foster parents.

Social workers shall have caseloads of 1:8, other than caseloads of 1:12 for rate level E. Therapists must provide therapy to children, parents, and foster parents. Each certified family home shall be assigned a trained support counselor with experience in residential treatment.

The support counselor shall have 60 hours of training in working with abused and neglected children, progressive crisis intervention, CPR and developing treatment plans for emotionally disturbed children before assignment to a home.

Each support counselor shall provide support service to the child and foster family, including but not limited to structuring a safe environment, collateral contacts, and any administrative or training needs to meet the child's needs and services plan. The child's needs and services plan shall be reviewed and approved by the foster parent.

Each support counselor shall arrange for coordination services with local education agencies and non-public schools where applicable.

A 24-hour on call administrator will be available to respond to emergency situations with 24/7 social work emergency response, with criteria and a timeframe for in person response. Psychiatric coverage must be available as needed for emergencies.

A treatment plan must be developed within one month of placement, addressing the needs for therapy, behavior modification services, support counselor services, psychotropic medication monitoring, respite services, family therapy and other services needed to return the child home, and education liaison services as needed to maintain the child in the classroom. Crisis prevention and intervention services must be available, as well as respite care services.

C. Estimated Human Resources and Funding Requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

Rates for ITFC

ITFC rates are set by state statute. Foster parents shall be paid at $1,200 per month. The agency shall provide a minimum average range of service per month represented by paid employee hours incurred by the FFA in-home support counselor. The IRT shall determine the appropriate service and rate level at the time of placement. For an eligible child from a group home program, the rate shall not exceed the rate paid for group home placement.

Schedule of FFA ITFC Rates effective July 1, 2001:

Service Level	A	B	C	D	E
In-Home Support Counselor Hours Per Month	98-114 hours	81-97 hours	64-80 hours	47-63 hours	Flex, as needed
Rate	$4,476	$4105	$3,721	$3,359	$2,985

When the IRT and the FFA agree, the following types of services may be provided in lieu of in-home support services:

a) Therapy,
b) Behavior modification services,
c) Support counselor services,
d) Psychotropic medication and monitoring,
e) Respite services,
f) Family therapy to aid in reunification.

A child can be placed at any rate level but cannot exceed 6 months at any rate level other than level E, unless it is determined to be in the best interests of the child buy the IRT and the child's foster parents. The IRT may extend a higher rate level for additional periods up to 6 months. There should a limit of 2 children per home, and more than one needs to be justified to the IRT.

Having surveyed numerous agencies in the county and state which have or have had ITFC programs, DCFS found a consensus among providers that current

programs remained small or were discontinued altogether for a variety of reasons including the following:

The reimbursement paid to the ITFC FFA foster parents of $1,200 per child per month is too low. When combined with ITFC limit of one, or at most two, children per home plus the higher costs of living in counties like Los Angeles, the current reimbursement rate is a disincentive to potential foster parents and FFA agencies to participate in an ITFC program.

Current and former ITFC agencies found that recruitment, training, support and retention of both high quality ITFC foster parents and in-home Support Counselors proved more costly and time-consuming than worthwhile.

DCFS first submitted an ITFC Plan to CDSS in 1998. DCFS subsequently developed contracts with 3 FFAs, which were allowed to lapse since the programs never scaled up to the expected capacity. These fledgling ITFC programs only developed a few homes, and the county only placed 4 children in them, two of whom were subsequently adopted by the treatment foster parents.

As the result of our recent survey of ITFC programs around the state and in light of the urgency and magnitude of the Katie A. Corrective Action Plan order, the County is asking CDSS for flexibility with some current regulations and approval for the following revised plan:

Reimburse individual ITFC foster parents at the rate of $2,400 per month per child. This $2,400 amount would be deducted from the current Level A Rate of $4,476. ITFC foster parents would be specifically guaranteed the entire $2,400 amount in the ITFC FFAs contract with Los Angeles County DCFS.

The balance of $2,076 for the Level A Rate would be paid to the ITFC FFA agency for the recruitment, training, support and retention of ITFC high-quality foster parents, as well as respite, flexible funding and other administrative costs.

All three current ITFC rate holding agencies in Los Angeles County have contracts with DMH and will be required to maintain that contract in order to participate in ITFC. This contract with DMH will enable co-payment for the positions of Support Counselor, therapist and family therapist with Medi-Cal funding. DMH and DCFS have agreed to fund these clinical services at a rate of $20,000 per slot per year.

Each ITFC agency would be required to adopt a specific trauma - focused treatment model that represents promising practice and evidence-based treatment for the target population and will be approved by DMH. (For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Structured

Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Dialectical Behavioral Therapy (DBT). All members of the ITFC foster family and treatment team, including foster parents, support counselors, therapists, social workers and permanency partners need to be trained in the theory, language and practice of the chosen trauma – focused therapeutic model. Because the permanency partners are also trained in the chosen treatment model, each ITFC child will progress along a continuum from intensive, individualized foster care into her permanent home using the same therapeutic language and concepts of the ITFC program.

The target population for ITFC is multi-need latency-age children and adolescents with serious emotional and/or behavioral needs and/or developmental disabilities. All children referred to the ITFC program will be identified by the RMP described elsewhere in this document. The RMP will ensure that 80 percent of the population to be served must be children in an RCL 12 or higher – rated group home. The RMP will also ensure that not more than 20percent of the children to be served in the ITFCs will be at risk of psychiatric hospitalization or placement in an RCL 12 group home or higher.

In April 2007, there were 843 children in RCL 12 or higher group homes and 330 in RCL 10 or 11 group homes. A total of 1,359 children were placed in all RCL group homes. Of those 268 were age 12 or younger and 197 of those children are in RCL 12 or higher group homes.

After two years of operation and a thorough review of feasibility and appropriateness, DCFS would like to expand the population of children to be served by the ITFC program to children already placed (80 percent) or at risk for placement (20 percent) in RCL 10 group homes.

DCFS has requested state approval to conduct a Procurement by Negotiation (PBN) for 60 beds with the three foster family agencies that currently maintain an ITFC rate for a 2 year term; utilize the Request For Statement of Qualifications (RFSQ) procurement method for an ITFC Foster Family Agency (ITFC FFA) contract solicitation the full 220 bed target; and obtain a 5 year contract term for the ITFC FFA contracts as a result of the ITFC FFA RFSQ.

It is anticipated that the proposed contract term for the Procurement by Negotiation would be October 1, 2007-September 30, 2009, unless terminated earlier; and the contract term for the contracts through the RFSQ process would be October 1, 2008-September 30, 2013. The overlap of the PBN Contracts and the Contracts resulting from the RFSQ would allow for the development of additional beds as the County attempts to obtain 220 ITFC beds. The full annual proposed DCFS contract amount for FY 2007-08 is estimated at $3,223,000 for the PBN contracts for placement costs.

Additional support costs for this program for DCFS will include one CSA I program manager.

Additionally, there would be EPSDT costs for FY 2007-08, with an annual cost of 60 slots at $20,000 per year or $1,200,000, including $88,000 of county match.

If the State grants the 5 year contract period for the contracts obtained through the RFSQ, the preliminary estimate for FY 2009-2014 is $59,083,000 for ITFC FFA Agreements since it is not anticipated that there will be a State rate increase for the placements.

Additionally, there would be EPSDT costs for FY 2009-2014 and the full annual amount would be 220 slots at $20,000 per year or $4,400,000, including $322,000 of county match.

The County is also proposing to provide the cost of staff and foster parent training in the models that are adopted. These training costs will include initial training in treatment practices, as well as ongoing consultation and technical assistance to assure fidelity to the practices that are implemented. DCFS estimates these costs to be approximately $60,000 per year.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. They will be supported by DCFS Deputy Director Lisa Parrish and DMH District Chief Gregory Leckrone.

E. Expected Outcomes

It is expected that a successful ITFC programs will significantly reduce or eliminate children aged 12 and under in or at risk of placement in RCL 12 or higher group homes and somewhat reduce children aged 13 and older in RCL 12 or higher group homes. In April 2007 there were 268 children aged 21 or younger in group homes and 197 of them were in facilities rated RCL 12 or higher.

F. Projected date for commencement of and completion of the activity

The expected contract award date for 60 beds is December 1, 2007. The expected award date for the full 220 beds is April 1, 2009. (Program Manager has recommended earlier start dates of October 1, 2007 and October 1, 2008 respectively.)

G. How the activity relates to specific obligations of the settlement agreement

This activity is consistent with all four of the specific settlement agreement objectives, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

Multidimensional Treatment Foster Care (MTFC)

In addition to implementation of ITFC, the County is also preparing to implement Multidimensional Treatment Foster Care (MTFC) as part of the Intensive In-Home Mental Health Services in the original County Plan.

MTFC is an intensive 6 to 9 month evidence-based program for youth with serious emotional and behavioral problems who are court-mandated to out-of-home placement. The program is a multi-component intensive foster care program targeting youth in or at-risk of group home care. The model includes an array of services and supports for the foster parent, biological/permanent placement family, and youth, including foster parent training and weekly supervision, individual and family therapy, parenting and behavioral skills interventions, intensive care-management and coordination, and 24-hour 7-day a week on-call support. The program is delivered by a team of master's and bachelor's level practitioners.

Referral Criteria:

i. Inclusion Criteria:
   - Age 12-17
   - EPSDT eligible
   - Available family/aftercare resource for permanent placement
   - Placement or at-risk of placement in RCL 12 or above facility

ii. Exclusion Criteria (Inappropriate referral):
   - Client requires secure environment to prevent harm to self or others

- Client currently enrolled in Wraparound, FSP, or other intensive service program

iii. Referral Mechanism:
- CSW completes universal referral form, including MTFC section
- Referral given to co-located DMH staff (system navigators) or to RMP when this program is implemented

DMH co-located staff to review referral, consult with CSW, review mental health history, coordinate referral with current provider if case is open, arrange for presentation using the DCFS RMP, consult with Community Development Team (CDT) members, and review with MTFC providers

Pre-authorization provided by co-located staff; final authorization provided by central authorization unit

Slot Capacity:
- Service Area One 20 slots
- Service Area Six 40 slots
- Service Area Seven 20 slots

DMH will be partnering with CIMH in the development and implementation of MTFC. CIMH developed the CDT training and technical assistance model designed to promote the sustainable model-adherent implementation of evidence-based practices by public sector mental health, juvenile justice and child welfare agencies and private providers. The proposed Los Angeles CDTs will include clinical training and administrative supports provided in three phases pre-implementation, implementation and sustainability. During these phases, 7 core processes occur that are designed to facilitate the successful implementation and sustainability of new practices. These processes are accomplished via a set of 7 distinct activities.

Training and ongoing technical assistance and consultation will be provided by Treatment Foster Care, Inc., the purveyor of the MTFC model.

DMH has completed a bidding process and identified agencies to develop the MTFC program as part of our Phase One activities.

C. Estimated Human Resources and Funding Requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

As part of the Phase One proposal DMH estimated that the clinical portion of the MTFC program could be supported with approximately $15,000 per slot of EPSDT. In discussions with contract providers and CIMH, it now appears that this figure may be overly conservative and additional EPSDT allocations are likely to be necessary to adequately support the program. Additionally, it will be important to provide comparable funding for both the ITFC and MTFC programs so that one is not unfairly advantaged over the other since these two programs will likely compete for foster families and clients.

At this time DMH is estimating that MTFC will require approximately $20,000 per slot per year of EPSDT to support the clinical program. This re-calculation results in a need for an additional $400,000 dollars of EPSDT, including $29,000 of county match per year, over that which was previously allocated.

In addition to these dollars for the clinical portion of the MTFC program, DCFS will be responsible for supporting the non-EPSDT costs associated with MTFC. These costs include a stipend to the foster parent to raise their monthly support fee to $2,400 per month, funding of a three quarter time foster parent recruiter/trainer/ Parent Daily Report call position at approximately $75,000 per year, the cost of respite care at approximately $300 per month, and for flexible funds of $125 per month. DCFS estimates the bed cost associated with these costs to be $27,000 per year x 80 beds or $2,160,000 per year.

DMH and DCFS will also explore the possible use of the ITFC rate to support the non-clinical services associated with the MTFC program alongside the continued use of EPSDT to finance the clinical aspect of the program.

D. The County Official with Direct Responsibility for the Action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. They will be supported by DMH District Chief Gregory Lecklitner and DCFS Deputy Director Lisa Parrish.

E. Expected Outcomes

The provision of MTFC is expected to improve social and emotional functioning, decrease aggressive and defiant behaviors, promote placement stability, and reduce timelines to permanency for those youth referred to the program.

F. Projected date for commencement of and completion of the activity

DMH has completed a procurement process and identifies agencies to implement the MTFC model. These agencies have held meetings with model developers and CIMH and have presented implementation plans. Staff recruitment and training will commence within two months of Board approval of this Corrective Action Plan and services will follow immediately. DMH anticipates that it will take 12 months from the date of commencement to full implementation of the MTFC program.

G. How the activity relates to specific obligations of the settlement agreement

This activity is consistent with all four of the specific settlement agreement objectives, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

VIII. Training Mechanisms Related to the Plan

A. Issue Requiring Response

The November 2006 Order of Judge Matz requires the County to provide a description of how the County Plan is modified to:

a) Elicit feedback from those DMH and DCFS workers who have received training to provide the mental health covered by the County Plan and to share this feedback with the Panel; and
b) Use this information in a way that will be helpful in uncovering any limitations of the current training curriculum to provide skills-based training as well as improve front-line practice as outlined by the Panel in their Fifth Report at 25-28.

B. Corrective Action

Both DMH and DCFS are taking steps to address these two concerns of the Court.

DMH has allocated a full-time Training Coordinator position for the Enhanced Specialized Foster Care Program in each service area. One on the responsibilities of the Training Coordinator is to identify and plan relevant areas of training in collaboration with other Training Coordinators, the training liaison of the Child Welfare Division, and the Training Divisions of both DMH and DCFS. With oversight over key elements of the Plan, DMH developed a written training plan to identify common strategies to most effectively utilize limited resources and to coordinate planning across the three SPAs. Since March 2006, local and countywide planning meetings have been held on an ongoing basis, with participation from local office staff and the training sections of DMH and DCFS. Six core cross training topics were identified and curriculum developed beginning with cross Department training called, "DMH 101" and "DCFS 101". Other cross training topics include: " Crisis intervention", "Understanding Emotional Disturbances and Mental Disorders", " Legal Issues in Treating Minors with Emotional Disturbances" and " Understanding Legal Issues in the Child Welfare System".

In support of the County Plan and in addition to the cross-joint training currently underway, the County will also develop and deliver training targeting DCFS front line staff and supervisors that focuses on increasing their knowledge and skill in recognizing potential signs-indicators of mental health issues as they engage-intervene with client families throughout the continuum of service. Based on core values and practice principles, the training incorporates and includes (but is not limited to) the effective use of the CIMH Screening Tool. The training will also make application of this screening/information gathering process to the unique situations associated with DCFS relative placements. For both in-home and out-of-home situations, the training will incorporate and reference out-stationed DMH staff deployed in accordance with the County Plan and focus on the key elements (knowledge, skills, protocols) of collaboration needed to facilitate linkage of DCFS children and family members with mental health resources (including further assessment, crisis intervention and treatment as needed.). This training will initially target those staff working in Service Areas 1, 6, and 7.

Recent coordination efforts have focused on capturing feedback and accurately tracking the large number and variety of training activities that are offered for staff and partners working in the three Service Areas and eight DCFS offices. Until a uniform electronic feedback mechanism is implemented within DMH, feedback will be collected for each training activity separately, and a summary of each training activity will be compiled and forwarded to the Child Welfare Division.

Concurrently and in collaboration with DMH, the DCFS Training Section will (initially) utilize its existing Training Coordinators and its Training Data System (TDS) to track/record feedback from DCFS staff who will receive training in conjunction with implementation of this phase of the County Plan.

A component of the Department's Inter-University Consortium (IUC) Training Contract, the DCFS/IUC TDS system is a web-based application that is accessible to all DCFS staff. The TDS provides notification and basic course information (overview, course objectives, target audience, logistics, pre-requisites etc.), and will be used to track sign ups/attendance and record training credit for DCFS staff participating in these targeted training events. Additionally, the TDS will be used to track evaluation/feedback provided by DCFS participants in key areas. Each participant will complete a feedback form for each training that they attend in support of County Plan. This information will be data entered into the TDS system so feedback summaries can be generated and reviewed. This information will be used to improve/enhance the quality and effectiveness of current trainings and to plan future training in collaboration with DMH.

To insure common elements of feedback are received from both DMH and DCFS staff, DMH utilizes a feedback form that contains similar and consistent information to the existing DCFS version. Areas of feedback to be solicited include; the relevance of training content to job training needs, the current knowledge/skill level of the participant, the content and degree to which the learning objectives are achieved, the organization and the effectiveness of the training approach/strategy that is used and an evaluation of the trainer. Participant feedback/ideas for additional training that is needed is also solicited.

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

The DMH Child Welfare Division requires additional staff at the countywide level in order to adequately address the scope, volume and variety of the training needs of the DMH/DCFS staff, services providers and other community partners involved in this effort. In order to provide a minimum of infrastructure and support, a training administrator at the Training Coordinator level is needed to coordinate planning across service areas and Departments and to develop and provide core curriculum that address the skills and knowledge needed by staff in a complex interagency setting. Additional training and protocols are also required in the area of appropriate EPSDT documentation and claiming, as well as

training around the various new mental health treatment options including intensive evidenced based programs and full service partnerships. This training coordinator will also work closely with the DCFS Training Section on the development of the training described above related to the incorporation of the use of the mental health screening tool into routine child welfare practice.

In addition, an ITC is needed for administrative/clerical support to track, gather and disseminate data, training announcements, and other written information in support of the coordination provided by the Child Welfare Division. Within the Child Welfare Division of DMH enhanced infrastructure and expertise is required to adequately partner with DCFS and provide support to line staff of both Departments.

Within DCFS and specifically the DCFS Training Section; as implementation of the County Plan proceeds and training expands across the Department's sizable workforce; additional administrative/clerical support resources will be needed. It is anticipated that a minimum of two Senior Typist Clerk positions will be required to insure the prompt tracking/recording of this feedback and information based on the expanded training offered in support of improved practice and implementation of the County Plan. A Training Coordinator position allocated at the Children's Services Administrator I level is needed to coordinate/oversee these training efforts and to address/support ongoing training needs as they surface with implementation of the County Plan components described herein.

DMH and DCFS are also need funds to support training, consultation, and technical assistance associated with a number of areas that have been of interest to the Court and the Panel. Examples of such areas include best practices for strategic planning, financing (especially regarding IV-E waiver and EPSDT), utilization management, social work and mental health, potential mentoring/coaching of staff needs assessment, project management, quality improvement, and so forth. An annual budget of $250,000, shared with DCFS and DMH is needed for these activities.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH.

Additionally, Mark Miller, the Director of the DCFS Training Section Bureau in collaboration with DMH District Chief Gregory Lecklitner and District Chief Martha Drinan for the DMH Training Bureau, along with local DCFS and DMH Regional Managers will have responsibility for this section of the Corrective Action Plan.

E. Expected outcomes

Current training activities will be monitored by the parallel training evaluation processes in place at both Departments. Feedback from staff will be uniformly collected and utilized in developing ongoing training; new formats and incorporating suggested training topics into new curriculum.

This information will be reviewed jointly by DCFS/DMH Leadership, will be utilized to improve existing training and plan future training events, and can/will be summarized and provided to the Panel in conjunction with overall updates on County Plan implementation.

F. Projected date for commencement of and completion of the activity

The tracking of feedback on the various training activities related to the Plan, i.e. cross training, joint training, as well as the presentation of special topics is a continuous and ongoing activity.

Mechanisms to insure feedback is collected, recorded, tracked and summarized for targeted training associated with the County Plan will be instituted within two months of approval of this County Plan revision and continue ongoing.

G. How the activity relates to specific obligations of the settlement agreement

Under Paragraph 6 of the settlement agreement, a central provision states that members of the class will receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law. Although the County contends that the current training curriculum and structure within DCFS is adequate and in compliance with State guidelines, the Panel has also suggested that efforts continue to improve the quality and effectiveness of existing interventions and modalities. The addition of 2 staff will greatly enhance the capacity of the new DMH/Child Welfare Division to provide the skills based training to front line staff as well as implement a more effective, uniform evaluation process. As noted, DCFS will maintain a comprehensive feedback evaluation mechanism with the Inter-University Consortium and will regularly provide this information to in regular reports to the court and the Panel.

IX. Impact of the Title IV-E Waiver on the Plan

A. Issue Requiring Response

The Judge Matz Order requires the County to provide a description of how the County Plan is modified to:

a) Continue to evaluate the Panel's proposal to obtain additional or new funding and to seriously consider the pursuit of any proposals the Panel recommends; and
b) Update information about how the County intends to redirect funds saved through the newly approved Federal IV-E waiver, which potentially gives the County much greater flexibility to spend funds or provide services for class members

B. Corrective Action

DCFS and DMH have been working very closely with the Panel members over the past few months and are very appreciative of the guidance and expertise offered. Central to this discussion is the County's plan to enter the Title IV-E Waiver on July 1, 2007. DCFS and Probation will be submitting a Title IV-E Waiver Implementation Plan to the Board of Supervisors by the end of June 2007 that will sequence the implementation of the Waiver strategies. It is currently projected that $21,000,000 in reinvestment funds will be available over the five years of the Waiver, resulting in an overage of $4,200,000 available each year. DCFS and Probation have agreed to split reinvestment funds in the first year on an 80/20 ratio, with 80 percent to be made available to DCFS. This leaves $3,378,000 available to DCFS in FY 2007–08. The availability of additional funding will assist in meeting the specific obligations of the settlement agreement but will not be solely focused on the mental health needs of the class.

The following describes the initial DCFS sequences:

1. Waiver Implementation – First Sequence Priorities

In partnership with our stakeholders and Probation, DCFS has identified the following Demonstration Project priority initiatives:

i. Expansion of Family Team Decision Making (FTDM) Conferences. DCFS will increase the number of FTDM facilitators available to allow a Permanency Planning Conference every 56 months for each child in group home placements as a first priority and children in out-of-home care over 24 months without a permanency resource as a second priority to ensure that plans for reunification, adoption or guardianship are expedited.

ii. Upfront Assessments for Mental Health, Substance Abuse and Domestic Violence for High Risk Cases, with Expanded Family Preservation Services. Through the use of an existing County Contracted Family Preservation agency, DCFS will establish an up-front assessment program in the DCFS Compton Regional Office, to

better serve families through an immediate thorough assessment of their needs. This will be achieved by utilizing experts in the areas of Mental Health, Substance Abuse and Domestic Violence to provide comprehensive assessments and, when appropriate, connecting families to treatment and ancillary services in the community, including expanded Family Preservation services, rather than taking children into care. Based on the volume of high risk referrals, strong partnerships with Family Preservation agencies, and the need for more coordinated linkage to Mental Health, Substance Abuse and Domestic Violence services, implementation will begin in the Compton office in the first year, with the expectation that in the next sequence of Waiver resourced activities the Lakewood, Metro North, Pomona and Santa Clarita offices will follow. Implementation will be phased into all DCFS offices over a 3-year period.

iii. The Prevention Initiative: Enhancement of Prevention Networks through Lead Agencies Initiative. This initiative will create networks of government and community partners that work together to support healthy communities, strong families and safe children by integrating prevention strategies at the community level. DCFS-funded prevention agencies will serve as network leads organized in a fashion to allow prioritization of intensive services to highest need families, including those already involved with DCFS and those where a crisis may arise that calls for immediate intervention. Separate from the Waiver, DCFS has $5,000,000 to reinvest in the initiative in FY 2007–08, but may seek Waiver funds in future sequences.

iv. Expansion of Family Finding and Engagement, through Specialized Permanency Units in 4 DCFS Regional Offices. Specialized Permanency Units consisting of 6 Generic CSWs (CSWs) with reduced caseloads (pending Union approval) will be established in four DCFS offices: Lakewood, Metro North, North Hollywood and Pomona. These Units will serve the most disconnected and longest waiting youth; those with no or limited family connections; multiple recent replacements; heavy substance abuse, recent psychiatric hospitalization; and repeated runaway youth. CSWs will utilize intensive family finding and engagement strategies and collaborate with internal and external resources to connect these youth to durable family attachments who will become permanency resources.

v. Dr. Charles Ferguson, from Sonoma State University, has been selected as the statewide evaluator for California's capped allocation demonstration projects. Beginning in July 2007 and periodically for

the next five years, his evaluation team will be conducting staff surveys and focus groups to gauge the changes to the service delivery system under the flexible funding environment.

2. Waiver Implementation – Next Sequence Priorities

By the beginning of FY 08-09, DCFS plans to implement the next sequence of priority initiatives or expansions of initiatives already underway, including:

a) Expansion of upfront assessments for high risk referrals with expanded Family Preservation;
b) Expansion of Family Team Decision Making Permanency Planning Conferences;
c) Expansion of Family Finding with Engagement Permanency Units;
d) Expansion of aftercare services through residentially based services and alternative program pilots;
e) Development and utilization of community based placements; and
f) Enhanced parent – child visitation.

As the Waiver Demonstration Project moves forward, each initiative will be evaluated on a regular basis, and outcome findings will be incorporated into the implementation plan. In addition, regular updates on the progress of the Demonstration Project will be provided to staff and stakeholders.

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

The Waiver strategies must be funded within the capped allocation. In the first sequence for DCFS implementation, DCFS will be requesting authority to fill 26 positions, primarily for FTDM facilitators.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. Additionally, Lisa Parrish, Deputy Director, DCFS, and Jitahadi Imara, Deputy Director, Probation, have responsibility for the activities described in this section of the Corrective Action Plan.

E. Expected outcomes

The project will give Los Angeles County the financial flexibility to make strategic investments in structural and programmatic reforms that are needed to better serve children and families in a cost neutral manner. To be effective, the child welfare system must be able to meet the multiple needs of children and families through the responsible use of the full spectrum of available government services and community supports. These efforts will build on the significant systems improvement efforts already underway among County Departments and their community partners.

The Waiver will allow the County funding flexibility to accelerate efforts to improve outcomes for children. The primary outcomes include:

a) Provision of more preventive services;
b) Increase the number and array of services to allow more children to remain safely in their home;
c) Reduce the reliance on out-of-home care through the provision of intensive, focused, individualized services;
d) Reduce the number of children and their length of stay in congregate care while ensuring that individualized case planning and appropriate community alternatives are in place first; and
e) Reduce the timelines to permanency.

F. Projected date for commencement of and completion of the activity

Implementation of the Waiver is scheduled for July 1, 2007 and the term of the Waiver period ends June 30, 2012. There is an opt-out provision in the Memorandum of Understanding between the State and the County that allows the County to opt-out of the Waiver with 60 days notice to the State. The opt-out provision would only be used if the County is unable to achieve the results anticipated due to the flexible funding allowed under the Waiver. The primary reasons that the County may choose to opt-out are unexpected economic changes that significantly increase the number of children entering care, or unanticipated cost increases that cannot be managed within the capped allocation.

G. How the activity relates to specific obligations of the settlement agreement

These activities are consistent with all four of the specific settlement agreement objectives, including the County's obligation to ensure that class members:

a) Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
b) Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
c) Be afforded stability in their placements, whenever possible; and
d) Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

X. Tracking Indicators

A. Issue Requiring Response

The Judge Matz Order required the County to provide a description of how the County Plan is modified to:

a) Use previously agreed upon tracking indicators for all class members and to provide reasonably meaningful outcome indicators;
b) Provide the Panel with a tracking log on a regular basis;
c) Provide on a periodic basis, additional information about the scope of resources devoted to the tasks tracked in the tracking log, the barriers impeding the completion of those tasks, and the measures of task achievement; and
d) Schedule regular meetings with the Panel.

B. Corrective Action

The County understands the need to provide tracking indicators for all class members and the requirement of providing meaningful outcome indicators related to service provision. DCFS and DMH recently presented updated information regarding the agreed upon twenty-one performance indicators and is continuing to work on refining this information with the expectation that regularly updated reports of the kind the Panel seeks will be available.

The County has also regularly provided the Panel with tracking reports describing implementation efforts, so-called tracking logs, and will continue to do so. Regular face-to-face consultations with the Panel have also been scheduled on a bi-monthly basis and additional consultation has occurred recently, particularly related to financing strategies. The Departments and the Panel have found these activities to be productive.

Beyond these ad hoc reports and opportunities to share experiences and expertise, the Departments view the design of an integrated management information protocol as of paramount importance in responding to the issues raised in the settlement agreement and in demonstrating the County's progress in complying with the terms of that agreement. The County will employ several strategies to develop a system that can reliably track and routinely report information that will describe the needs of children served by the child welfare system, the type and intensity of service provision, and the outcomes associated with the implementation of the elements of this plan, particularly as they relate to agreed upon performance indicators and exit criteria.

One of the top priorities in this regard is the development of a capacity to assess and analyze the various needs associated with children and youth across the child welfare spectrum. In particular, this kind of analysis can be helpful in identifying the needs of children and youth who come to the attention of child welfare and remain at home or placed with relatives. Services targeted to meet the needs of this population in a timely manner offer the potential to reduce entry or further penetration into the child welfare system and shorten timelines to reunification and permanency. This is but one example of the value of using data and analysis to inform practice in a way that supports child welfare and mental health outcomes.

DMH and DCFS will form an information management team, including leadership from both Departments representing technical, administrative, programmatic, legal, and financial sectors. This team will develop a shared protocol that will describe the information to be collected, the source of the information, how and when the information will be retrieved, how it will be shared, what reports will be generated, at what intervals, and who will be responsible for each of these tasks. It is recommend that the Departments assign a single high level manager to act as the sponsor for this work and that each Department allocates the appropriate staff to participate in this project on an ongoing basis. The Departments also recognize the interest and expertise of the Panel in this endeavor and will solicit their involvement as well.

Until recently DMH and DCFS have been limited in their ability to share client information by legal barriers related to confidentiality. However, on June 11, 2006 Judge Matz issued an Order permitting DCFS and DMH to share client data for the purposes of matching to identify individuals receiving services from both Departments.

DMH and DCFS are also exploring the shared use of workflow software that may provide much-needed technological support for the mutual tracking of client contacts at entry into the respective system and ongoing engagement with various system processes and programs.

Beyond the needs to track performance indicators, service delivery and outcomes, and exit criteria, this shared unit will provide technical support for the various utilization management activities, especially those directed to high level placements and services such as RCL 12 and 14 placement, Community Treatment Facilities, psychiatric hospitalizations, Foster Family Agencies, and D-rate homes.

C. Estimated human resources and funding requirements

The following costs and staffing requirements will be subject to further review and discussion with the Chief Executive Office and will be incorporated, as needed, in the Departments' budgets during the Supplemental Changes phase of the budget process.

The data collection, analysis, and reporting requirements related to the activities associated with the Katie A. lawsuit are considerable and will require substantial staffing commitments and levels of inter-departmental cooperation. At this time we estimate that each Department needs one Chief Research Analyst, Behavioral Science, one Information Systems Analyst II, one Senior Typist Clerk, and one Intermediate Typist Clerk to help design, support, and maintain the tracking requirements.

In addition to these dedicated staff positions, the Departments also need funds to support the work of a consultant group in designing the systems, operations, and technical aspects of this integrated program. This consulting group will assist the County in performing, analyzing, and reporting various spot studies related to quality improvement as well as in the ongoing management of service utilization and outcome information. The Departments estimate that $100,000 will be required for this task in the first year and then an additional $50,000 to support the work of the consultants in each subsequent year.

D. The County official with direct responsibility for the action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director, Sandra D. Thomas from DMH. Additionally, DMH District Chief Greg Lecklitner and DCFS Information Systems Specialist Cecelia Custodio with the DCFS Bureau of Information Services will be responsible for this action.

E. Expected outcomes

The County recognizes the fundamental need to use reliable administrative, financial, and clinical information to guide decision-making in achieving the

objectives of the settlement agreement. The collaborative activities outlined above are intended to provide the capacity to generate ongoing routine reports related to performance indicators, service need, utilization and outcomes, and exit criteria. As proposed by the Panel, the Departments intend to use this resource to support needs based planning, benchmarking, performance analysis of structures, jobs, and processes, investment financing, and performance monitoring strategies.

F. Projected date for commencement of and completion of the activity

The Departments anticipate that it will take approximately six months from the date of Board approval to recruit, hire, and train the staff for this program.

G. How the activity relates to specific obligations of the settlement agreement

This activity will support achievement of all four of the settlement agreement objectives.

XI. Exit Criteria and Formal Monitoring Plan

A. Issue Requiring Response

The November 2006 Order of the Court requires the County to provide a description of how the County Plan is modified to:

a) Identify exit criteria reflective of the core objectives of the Agreement
b) Develop a more comprehensive monitoring plan than those measures previously proposed to the Court
c) Consider the Panel's threefold measure of compliance including:
    i. successful completion of a meaningful implementation plan (i.e., a plan approved by the Court); and
    ii. a passing score from a qualitative review; and
    iii. acceptable progress on outcomes indicators
d) Provide preliminary projections for Phase Two activities, timeframes, and resource requirements

B. Corrective Action

The Plaintiff attorneys, Panel, and County have agreed to work together over the next 3 months to draft a set of mutually agreeable exit criteria and monitoring plan in response to the Court's direction on this matter.

Additional Staffing Requirements to Support the Implementation of the Corrective Action Plan

This Corrective Action Plan significantly expands the staffing and activities currently underway, particularly in Service Areas 1, 6, and 7. In order to support these additional staff and responsibilities, these service areas will need additional administrative support. DMH will need a Program Head, a Staff Assistant II, and a Secretary III for each of these three service areas.

Additionally, DCFS will need to augment staffing within the Office of the Medical Director to oversee these activities and coordinate their implementation with DMH. A Division Chief, two CSA Is, and a Senior Secretary III position are needed for this purpose.

ATTACHMENT II

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FISCAL IMPACT TO DCFS AND DMH OF KATIE A CORRECTIVE ACTION PLAN
SUMMARY

Department	FTE's	S&EB	S&S	Other Charges	Total Appropriation	DCFS Intrafund	Net Appropriation	Revenue				Net County Cost		
								EPSDT FFP	EPSDT Scf	Medi-Cal MAA	Total Revenue	Match NCC	Other NCC	Total NCC
Department of Mental Health	151.0	$ 12,654,227	$ 54,389,000	$ -	$ 67,043,227	$ 3,432,000	$ 63,611,227	$ 28,162,197	$ 24,039,251	$ 900,813	$ 53,102,261	$ 4,122,945	$ 5,911,537	$ 10,034,482
Department of Children & Families Services	63.0	5,200,375	1,206,264	16,831,174	23,237,813	-	23,237,813			-	-	23,237,813	-	23,237,813
Grand Total	214.0	$ 17,854,602	$ 55,595,264	$ 16,831,174	$ 90,281,040	$ 3,432,000	$ 86,849,040	$ 28,162,197	$ 24,039,251	$ 900,813	$ 53,102,261	$ 27,360,758	$ 5,911,537	$ 33,272,295

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FISCAL IMPACT TO DMH OF KATIE A CORRECTIVE ACTION PLAN
DIRECTLY-OPERATED PROGRAMS

Program Name	FTEs	S & EB	S & S	Total Appropriation	Revenue				Net County Cost	
					EPSDT - FFP	EPSDT - SGF	Medi-Cal - MAA	Total Revenue	Match NCC	Other NCC
Child Welfare Division	9.0	$ 744,814	$ 44,000	$ 788,814	-	-	-	-	-	$ 788,814
CSOC Foster Family Agency Wraparound	19.0	1,364,600	284,000	1,648,600	-	-	347,733	347,733	-	1,300,867
Service Area 1, 6, 7 Administration	9.0	763,429	132,000	895,429	447,715	382,169	-	829,884	65,545	-
Countywide MAT Assessment/Screening	26.0	2,101,133	382,000	2,483,133	-	-	174,720	174,720	-	2,308,413
Service Area 1, 6, 7 Assessment/Screening	9.0	985,128	144,000	1,129,128	564,564	481,912	-	1,046,476	82,652	-
Service Area 6, 7 Youth & Family Teams	43.0	3,288,344	640,000	3,928,344	1,964,172	1,676,617	-	3,640,789	287,555	-
Service Area 1, 6, 7 Foster Family Agencies	16.0	1,358,492	256,000	1,614,492	807,246	689,065	-	1,496,311	118,181	-
Resource Management Process	15.0	1,651,803	240,000	1,891,803	-	-	378,360	378,360	-	1,513,443
D-Rate Program	5.0	396,484	78,000	474,484	237,242	202,510	-	439,752	34,732	-
Total - Directly Operated Programs	151.0	$ 12,654,227	$ 2,200,000	$ 14,854,227	$ 4,020,939	$ 3,432,273	$ 900,813	$ 8,354,025	$ 588,665	$ 5,911,537

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FISCAL IMPACT TO DMH OF KATIE A CORRECTIVE ACTION PLAN
CONTRACTED PROGRAMS

Program Name	S & S Contracts	Total Appropriation	DCFS Intrafund Transfer	Net Appropriation	Revenue			Match NCC
					EPSDT FFP	EPSDT SCF	Total Revenue	
Countywide MAT Assessment	$ 17,160,000	$ 17,160,000	$ 3,432,000	$ 13,728,000	$ 6,864,000	$ 5,859,110	$ 12,723,110	$ 1,004,890
Countywide MAT Treatment	16,818,000	16,818,000	-	16,818,000	8,409,000	7,177,922	15,586,922	1,231,078
Countywide Family Foster Agency Treatment	6,000,000	6,000,000	-	6,000,000	3,000,000	2,560,800	5,560,800	439,200
Wraparound Treatment Costs	7,236,000	7,236,000	-	7,236,000	3,618,000	3,088,325	6,706,325	529,675
Intensive Treatment Foster Care	1,200,000	1,200,000	-	1,200,000	600,000	512,160	1,112,160	87,840
Multi-Dimensional Treatment Foster Care	400,000	400,000	-	400,000	200,000	170,720	370,720	29,280
Multi-Systemic Therapy	400,000	400,000	-	400,000	200,000	170,720	370,720	29,280
At-Risk Treatment Cost	2,975,000	2,975,000	-	2,975,000	1,487,500	1,269,730	2,757,230	217,770
Total - Contracted Programs	$ 52,189,000	$ 52,189,000	$ 3,432,000	$ 48,757,000	$ 24,378,500	$ 20,809,488	$ 45,187,988	$ 3,569,012

COUNTY OF LOS ANGELES - DEPARTMENT OF CHILDREN AND FAMILY SERVICES
FISCAL IMPACT TO DCFS OF KATIE A CORRECTIVE ACTION PLAN

Program Name	FTEs	S & EB	S & S	Other Charges	Total Appropriation	NCC
Screening and Assessment of Class Members	14.0	$ 948,384	$ 319,244	$ -	$ 1,267,628	$ 1,267,628
Provision of Intensive Home-Based Mental Health Services	17.0	1,501,709	253,660	-	1,755,369	$ 1,755,369
Provision of Mental Health Services to Children in D-Rate Homes	4.0	342,198	47,920	-	390,118	$ 390,118
Expansion of Wraparound	19.0	1,665,774	227,620	15,645,960	17,539,354	$ 17,539,354
Implementation of Treatment Foster Care	1.0	107,442	11,980	1,185,214	1,304,636	$ 1,304,636
Training Mechanisms Related to Plan	4.0	260,122	297,920	-	558,042	$ 558,042
General Infrastructure	4.0	374,746	47,920	-	422,666	$ 422,666
Total	63.0	$ 5,200,375	$ 1,206,264	$ 16,831,174	$ 23,237,813	$ 23,237,813

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FISCAL IMPACT TO DMH OF KATIE A CORRECTIVE ACTION PLAN

Programs	FTEs	S & EB	Program Cost	Total Approp.	EPSDT	Medi-Cal MAA	NCC	Comments
1. Screening and Assessment of Class Members	44.0	4,905,690	$36,953,000	$41,858,690	$33,312,336	$174,720	$8,371,634	
2. Provision of Intensive Home-based Mental Health Services as Alternatives to Group Home Care	15.0	1,891,803	0	1,891,803	945,901	378,360	567,542	
3. Provision of Mental Health Services to Children in Foster Family Agencies	16.0	1,614,492	6,000,000	7,614,492	7,057,311	0	557,181	
4. Provision of Mental Health Services to Children Placed in D-rate homes	43.0	3,928,344	0	3,928,344	3,640,789	0	287,555	
5. Continued Use of Existing Mental Health Resources	0.0	0	400,000	400,000	370,000	0	30,000	
6. Expansion of Wraparound	19.0	1,648,600	7,236,000	8,884,600	6,706,325	347,733	1,830,542	
7. Implementation of Treatment Foster Care	0.0	0	1,600,000	1,600,000	1,482,160	0	117,840	
8. Training Mechanisms Related to the Plan	9.0	788,814	0	788,814	0	0	788,814	
9. Impact of the Title IV-E Waiver on the Plan	0.0	0	0	0	0	0	0	
10. Tracking Indicators	0.0	0	0	0	0	0	0	
Total	146.0	$ 14,777,743	$ 52,189,000	$ 66,966,743	$ 53,514,822	$ 900,813	$12,551,108	

ATTACHMENT III

CONTRACT NO. _____

AMENDMENT NO. _____

THIS AMENDMENT is made and entered into this ____ day of _____, 2007, by and between the COUNTY OF LOS ANGELES (hereafter "County") and _____ (hereafter "Contractor").

WHEREAS, County and Contractor have entered into a written Agreement, dated _____, identified as County Agreement No._____, and any subsequent amendments (hereafter collectively "Agreement"); and

WHEREAS, for Fiscal Year 2007-08 only, County and Contractor intend to amend Agreement only as described hereunder; and

WHEREAS, for Fiscal Year 2007-08 only, County and Contractor intend to amend Agreement to implement the Court-ordered modifications to the Countywide Enhanced Specialized Foster Care Mental Health Services Plan (County Plan) by providing funding for increased mental health services for children and youth in foster care who are enrolled in DCFS Wraparound and Treatment Foster Care services, in Foster Family Homes, and expansion of the Multidisciplinary Assessment Team program. Modifications to this County Plan are consistent with the County's obligations under the settlement agreement reached in the Katie A. class action litigation; and

WHEREAS, for Fiscal Year 2007-08 only, County and Contractor intent to amend Agreement to implement the Court-ordered changes to the services reflected in the

County Plan by adding $_____ in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State General Funds, $_____ EPSDT-Federal Financial Participation Medi-Cal, and $_____ of Intrafund Transfer from the Department of Children and Family Services for a combined total of $_____ to the Maximum Contract Amount of this Agreement; and

WHEREAS, for Fiscal Year 2007-08, the revised MCA is $_____; and

WHEREAS, for Fiscal Year 2007-08, County and Contractor intend to amend Agreement to add Service Exhibit(s) for "_____". **(IF APPLICABLE)**

NOW, THEREFORE, County and Contractor agree that Agreement shall be amended only as follows:

1. Paragraph 4 (FINANCIAL PROVISIONS), Attachment II, FINANCIAL EXHIBIT A (FINANCIAL PROVISIONS), Subparagraph B (Reimbursement For Initial Period) shall be deleted in its entirety and the following substituted therefor:

   "B. REIMBURSEMENT FOR INITIAL PERIOD: The Maximum Contract Amount for the Initial Period of this Agreement as described in Paragraph 1 (TERM) shall not exceed _____ _____DOLLARS ($_____) and shall consist of County, State, and/or Federal funds as shown on the Financial Summary."

2. Financial Summary -__ for Fiscal Year 2007-2008 shall be deleted in its entirety and replaced with Financial Summary –__ for Fiscal Year 2007-2008, attached hereto and incorporated herein by reference. All references in Agreement to

Financial Summary -__ for Fiscal Year 2007-2008 shall be deemed amended to state "Financial Summary –__ for Fiscal Year 2007-2008."

3. Financial Summary -__ for Fiscal Year 2008-2009 shall be deleted in its entirety and replaced with Financial Summary –__ for Fiscal Year 2008-2009, attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary -__ for Fiscal Year 2008-2009 shall be deemed amended to state "Financial Summary –__ for Fiscal Year 2008-2009." **(IF APPLICABLE)**

4. Financial Summary -__ for Fiscal Year 2009-2010 shall be deleted in its entirety and replaced with Financial Summary –__ for Fiscal Year 2009-2010, attached hereto and incorporated herein by reference. All references in Agreement to Financial Summary -__ for Fiscal Year 2009-2010 shall be deemed amended to state "Financial Summary –__ for Fiscal Year 2009-2010." **(IF APPLICABLE)**

5. Service Delivery Site Exhibit ___ shall be deleted in its entirety and replaced with Service Delivery Site Exhibit ___, attached hereto and incorporated herein by reference. All references in Agreement to Service Delivery Site Exhibit ___ shall be deemed amended to state Service Delivery Site Exhibit ___.

6. A Service Exhibit for "_____" shall be added to this Agreement. **(IF APPLICABLE)**

7. Contractor shall provide services in accordance with the Contractor's Fiscal Year _____Negotiation Package for this Agreement and any addenda thereto approved in writing by Director.

8. Except as provided in this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused used this Amendment to be subscribed by County's Director of Mental Health or his designee, and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

_____
CONTRACTOR

By _____

Name _____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT ADMINISTRATION:

DEPARTMENT OF MENTAL HEALTH

By _____
Chief, Contracts Development
and Administration Division

Contractor Name:
Legal Entity Number:
Agreement Period:
Fiscal Year:

DMH Legal Entity Agreement
Attachment III
The Financial Summary -
Amendment No.

LINE #	COLUMNS / DESCRIPTION	1 MAXIMUM CONTRACT ALLOCATION TOTALS	2 LOCAL MHP NON MEDI-CAL	3 DCFS STOP SGF 70% County Local 30%	4 MAA and NON-EPSDT MEDI-CAL PROGRAMS FFP 50% County Local 50%	5 EPSDT MEDI-CAL PROGRAM FFP 50% SGF - EPSDT 42.68% County Local 7.32%	6 HEALTHY FAMILIES FFP 65% County Local 35%
		Sum of 2 + 3 + 4 + 5+ 6 = 1					
				Categorical Restricted CGF	Local Match share for claiming Certified Public Expenditure Categorically Restricted Local Funds** (see footnote)		
1	A. Contractual Limitation By Responsible Financial Party:						
2	CGF*	$ -		-	-	-	-
3	CGF - Psychiatric Emergency Services (PES) (NCC)	-					
4	CGF - Transitional Residential Program (NCC)	-					
5	SAMHSA, CFDA #93.958	-					
6	SAMHSA - Child Mental Health Initiative, CFDA #93.104	-					
7	SAMHSA - Targeted Capacity Expansion, CFDA #93.243	-					
8	PATH, CFDA #93.150	-					
9	CalWORKs - Flex Fund	-					
10	CalWORKs - Mental Health Services (MHS)	-					
11	CalWORKs - Community Outreach Services (COS)	-					
12	CalWORKs - Families Project - Client Support Services	-					
13	CalWORKs - Families Project - MHS & Targeted Case Management	-					
14	CalWORKs - Families Project - COS	-					
15	DPSS - GROW	-					
16	DCFS AB 2994	-					
17	DCFS Family Preservation	-					
18	DCFS Star View Life Support PHF	-					
19	DCFS Independent Living	-					
20	DCFS STOP (70%)	-		-			
21	DCFS Medical Hubs	-					
22	DCFS Basic MH Services Enhanced Specialized Foster Care	-					
23	DCFS Intensive In-Home Enhanced Specialized Foster Care	-					
24	DCFS - Multidisciplinary Assessment and Treatment (MAT)	-					
25	DCFS - Wraparound	-					
26	Probation - Mentally Ill Offender Crime Reduction Program (MIOCR)	-					
27	Schiff-Cardenas - M.H. Screening, Assessment, and Treatment (MHSAT)	-					
28	Schiff-Cardenas - Multi-Systemic Therapy Program (MST)	-					
29	Sheriff Dept - Mentally Ill Offender Crime Reduction Program (MIOCR)	-					
30	AB 34/AB 2034	-					
31	ADPA AB 34/AB 2034 Housing	-					
32	DHS-OAPP HIV/AIDS	-					
33	DHS Dual Diagnosis	-					
34	DHS Social Model Recovery	-					
35	DHS LAMP	-					
36	HIV AIDS	-					
37	IDEA (AB 3632 - SEP), CFDA #84.027	-					
38	SB 90 (AB 3632 - SEP)	-					
39	AB3632 - SEP (SB 1807)	-					
40	Mental Health Services Act (MHSA)	-					
41	Mental Health Services Act (MHSA) - Plan I:						
42	A. Child						
43	One Time Cost	-					
44	Client Supportive Services (Flex Funds)	-					
45	Mental Health Services	-					
46	B. TAY						
47	One Time Cost	-					
48	Client Supportive Services (Flex Funds)	-					
49	Mental Health Services	-					
50	C. Adult						
51	One Time Cost	-					
52	Client Supportive Services (Flex Funds)	-					
53	Mental Health Services	-					
54	D. Older Adult						
55	One Time Cost	-					
56	Client Supportive Services (Flex Funds)	-					
57	Mental Health Services	-					

Contractor Name:
Legal Entity Number:
Agreement Period:
Fiscal Year:

DMH Legal Entity Agreement
Attachment III
The Financial Summary
Amendment No.

LINE #	DESCRIPTION	1 MAXIMUM CONTRACT ALLOCATION TOTALS	2 LOCAL MHP NON MEDI-CAL	3 DCFS STOP SGF 70% County Local 30%	4 MAA and NON-EPSDT MEDI-CAL PROGRAMS FFP 50% County Local 50%	5 EPSDT MEDI-CAL PROGRAM FFP 50% SGF - EPSDT 42.68% County Local 7.32%	6 HEALTHY FAMILIES FFP 65% County Local 35%
	COLUMNS		Sum of 2 + 3 + 4 + 5 + 6 = 1				
				Categorical Restricted CGF	Local Match share for claiming Certified Public Expenditure Categorically Restricted Local Funds** (see footnote)		
58	Mental Health Services Act (MHSA) - Plan II						
59	A. Child						
60	Integrated MH/COD Services	-					
61	Family Crisis Services - Respite Care	-					
62	One Time Cost	-					
63	B. TAY						
64	Drop-In Centers	-					
65	Probation Camps	-					
66	One Time Cost	-					
67	C. Adult						
68	Wellness Centers - Non Client Run	-					
69	Wellness Centers - Client Run	-					
70	IMD Step Down	-					
71	Safe Haven	-					
72	One Time Cost	-					
73	D. Older Adult						
74	Field Capable Clinical Services						
75	One Time Cost	-					
76	Client Supportive Services (Flex Funds)	-					
77	Mental Health Services	-					
78	Older Adult Service Extenders	-					
79	Older Adult Training	-					
80	One Time Cost	-					
81	E. Cross-Cutting						
82	Urgent Care	-					
83	Enriched Residential Services	-					
84	One Time Cost	-					
85	Mental Health Services Act (MHSA) - Plan III	-					
86	Mental Health Services Act (MHSA) - AB 2034 Services	-					
87	Medi-Cal, Healthy Families, or MAA FFP	-			-	-	-
88	SGF - EPSDT	-				-	
89	***Maximum Contract Amount (A)***	$ -	-				
90	**B. Third Party:**						
91	Medicare	-					
92	Patient Fees	-					
93	Insurance	-					
94	Other	-					
		-					
95	***Total Third Party (B)***	-	-	-	-	-	-
96	**GROSS PROGRAM BUDGET (A+B)**	$ -	-	-	-	-	-

Footnote

* The Department is developing the parameters for authorizing the shift of CGF among the various programs identified in columns 2, 3, 4, 5, and 6. These parameters will be incorporated by a separate contract amendment during the year.

** These Local Funds are restricted in compliance with specific statutory, regulatory, and contractual requirements and obligations that are conditions for Medi-Cal reimbursement of Short-Doyle Medi-Cal claims. California Code of Regulations Title 9, Division 1, Chapter 11, Subchapter 4, Article 1, paragraph 1840.112 MHP Claims Certification and Program Integrity and Federal Code of Regulations, Title 42, Section 438.608.

Revised: 6/18/07

Contractor Name:
Legal Entity No.:
Agreement Period:
Fiscal Year:

DMH Legal Entity Agreement
The Rate Summary
Amendment No.

MENTAL HEALTH SERVICES		Mode of Service	Service Function Code (SFC) Range	Provisional Rates Negotiated NR	Provisional Rates Cost Reimb. CR	Provider Numbers
A. 24-HOUR SERVICES						
Hospital Inpatient		05	10 - 18			
Hospital Administrative Day		05	19			
Psychiatric Health Facility (PHF)		05	20 - 29			
SNF/Intensive		05	30 - 34			
IMD/STP Basic (No Patch)	Beds 1-59	05	35			
	Beds 60 & over	05	35			
Patch for IMD		05	36 - 39			
Mentally Ill Offenders	Regular	05	36 - 39			
	Indigent	05	36 - 39			
IMD - Like		05	36 - 39			
IMD (w/Patch) Sub-Acute (60 days)		05	38			
Adult Crisis Residential		05	40 - 49			
Residential Other		05	60 - 64			
Adult Residential		05	65 - 79			
Semi - Supervised Living		05	80 - 84			
Independent Living		05	85 - 89			
MH Rehab Centers		05	90 - 94			
B. DAY SERVICES						
Vocational Services		10	30 - 39			
Socialization		10	40 - 49			
SNF Augmentation		10	60 - 69			
Day Treatment Intensive: Half Day		10	81 - 84			
Day Treatment Intensive: Full Day		10	85 - 89			
Day Rehabilitative: Half Day		10	91 - 94			
Day Rehabilitative: Full Day		10	95 - 99			
C. OUTPATIENT SERVICES						
Targeted Case Management Services (TCMS), formerly Case Management Brokerage		15	01 - 09			
Mental Health Services		15	10 - 19/ 30 - 59			
Therapeutic Behavioral Services (TBS)		15	58			
Medication Support		15	60 - 69			
Crisis Intervention		15	70 - 79			
D. OUTREACH SERVICES						
Mental Health Promotion		45	10 - 19			
Community Client Services		45	20 - 29			
E. SUPPORT SERVICES						
Life Support/Board & Care		60	40 - 49			
Case Management Support		60	60 - 69			
Client Supportive Services (Cost Reimbursement)		60	64 70 - 79			
F. Medi-Cal Administrative Activities (MAA)						
MAA		55	01 - 35			

DMH Amendment Summary

LEGAL ENTITY NAME:_____

Contract No.:_____ Legal Entity No.: _____ Amendment No. _____

LIST OF FUNDING SOURCES

(Please check all applicable funding for Amendment only.)

1	CGF	
2	CGF - Psychiatric Emergency Services (PES) (NCC)	
3	CGF – Transitional Residential Program (NCC)	
4	SAMHSA, CFDA #93.958	
5	SAMHSA – Child Mental Health Initiative, CFDA #93.104	
6	SAMHSA – Targeted Capacity Expansion, CFDA #93.243	
7	PATH, CFDA #93.150	
8	CalWORKs – Flex Fund	
9	CalWORKs – Mental Health Services (MHS)	
10	CalWORKs – Community Outreach Services (COS)	
11	CalWORKs – Families Project – Client Support Services	
12	CalWORKs – Families Project – MHS & Targeted Case Management	
13	CalWORKs – Families Project - COS	
14	DPSS – GROW	
15	DCFS AB 2994	
16	DCFS Family Preservation	
17	DCFS Star View Life Support PHF	
18	DCFS Independent Living	
19	DCFS STOP (70%)	
20	DCFS Medical Hubs	
21	DCFS Basic MH Services Enhanced Specialized Foster Care	
22	DCFS Intensive In–Home Enhanced Specialized Foster Care	
23	DCFS – Multidisciplinary Assessment and Treatment (MAT)	
24	DCFS - Wraparound	
25	Probation – Mentally Ill Offender Crime Reduction Program (MIOCR)	
26	Schiff-Cardenas – M.H. Screening, Assessment, and Treatment (MHSAT)	
27	Schiff-Cardenas – Multi-Systemic Therapy Program (MST)	
28	Sheriff Dept – Mentally Ill Offender Crime Reduction Program (MIOCR)	
29	AB 34/AB 2034	
30	ADPA AB 34/AB 2034 Housing	
31	DHS-OAPP HIV/AIDS	
39	Mental Health Services Act (MHSA)	
40	MHSA – Plan I - Child – One Time Cost	
41	MHSA – Plan I - Child – Client Supportive Services (Flex Funds)	
42	MHSA – Plan I - Child – Mental Health Services	
43	MHSA – Plan I - TAY – One Time Cost	
44	MHSA – Plan I - TAY – Client Supportive Services (Flex Funds)	
45	MHSA – Plan I - TAY – Mental Health Services	
46	MHSA – Plan I - Adult – One Time Cost	
47	MHSA – Plan I - Adult – Client Flex Funds Supportive Services (Flex Funds)	
48	MHSA – Plan I - Adult – Mental Health Services	
49	MHSA – Plan I - Older Adult – One Time Cost	
50	MHSA – Plan I - Older Adult - Client Supportive Services (Flex Funds)	
51	MHSA – Plan I - Older Adult - Mental Health Services	
52	MHSA – Plan II - Child – Integrated MH/COD Services	
53	MHSA – Plan II – Child - Family Crisis Services – Respite Care	
54	MHSA – Plan II – Child - One Time Cost	
55	MHSA – Plan II – TAY –Drop-In Centers	
56	MHSA – Plan II – TAY – Probation Camps	
57	MHSA – Plan II – TAY – One Time Cost	
58	MHSA – Plan II – Adult – Wellness Centers-Non Client run	
59	MHSA – Plan II – Adult – Wellness Centers-Client run	
60	MHSA – Plan II – Adult - IMD Step Down	
61	MHSA – Plan II – Adult – Safe Haven	
62	MHSA – Plan II – Adult – One Time Cost	
63	MHSA – Plan II – Older Adult – Field Capable Clinical Services	
64	MHSA – Plan II – Older Adult – FCCS – One Time Cost	
65	MHSA – Plan II – Older Adult – FCCS – Client Supportive Services (Flex Funds)	
66	MHSA – Plan II – Older Adult – FCCS – Mental Health Services	
67	MHSA – Plan II – Older Adult – Older Adult Service Extenders	
68	MHSA – Plan II – Older Adult – Older Adult Training	
69	MHSA – Plan II – Older Adult – One Time Cost	

DMH Amendment Summary

LEGAL ENTITY NAME:_____

Contract No.:_____ Legal Entity No.: _____ Amendment No. _____

32	DHS Dual Diagnosis	
33	DHS Social Model Recovery	
34	DHS LAMP	
35	HIV AIDS	
36	IDEA (AB 3632 – SEP), CFDA #84.027	
37	SB 90 (AB 3632 – SEP)	
38	AB3632 – SEP (SB 1807)	

70	MHSA – Plan II – Cross-Cutting – Urgent Care	
71	MHSA – Plan II – Cross-Cutting – Enriched Residential Services	
72	MHSA – Plan II – Cross-Cutting – One Time Cost	
73	Mental Health Service Act (MHSA) – Plan III	
74	Mental Health Services Act (MHSA) – AB 2034 Services	
75	Medi-Cal, Healthy Families, or MAA FFP	
76	SGF - EPSDT	

FUNDING SOURCE(S) (Select from Funding Sources listed above for Amendment.)

(See Financial Summary(ies) for funding details to MCA.)

AMOUNT Increase/Decrease	**FISCAL YEAR**	**MCA**

AMENDMENT ACTION(S): **BOARD ADOPTED DATE:** _____ **EFFECTIVE DATE:**_____

New Headquarters' (HQ) Address: _____ HQ Sup. District: _____

_____ Service Area(s): _____

ADD OR DELETE SERVICE SITE(S):

Name	Address	Sup. Dist.	Svc. Area(s)	Prov. No.

Deputy Director:_____ Lead Manager: _____.

Revised: FY 06-07 Agreement Summary 5-08-07